1-1-2004

The role of education and support in the vocational development and recovery of young adults with psychiatric disabilities.

Kimberly S. Bisset
University of Massachusetts Amherst

THE ROLE OF EDUCATION AND SUPPORT IN THE VOCATIONAL DEVELOPMENT AND RECOVERY OF YOUNG ADULTS WITH PSYCHIATRIC DISABILITIES

A Dissertation Presented

by

KIMBERLY S. BISSET

Submitted to the Graduate School of the
University of Massachusetts, Amherst in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

September 2004

School of Education

THE ROLE OF EDUCATION AND SUPPORT IN THE VOCATIONAL DEVELOPMENT AND RECOVERY OF YOUNG ADULTS WITH PSYCHIATRIC DISABILITIES

A Dissertation Presented

by

KIMBERLY S. BISSET

Approved as to style and content by:

Kevin Nugent, Chair

Grace Craig, Member

Sangeeta Kamat, Member

Sally Powers, Member

Andrew Effrat, Dean
School of Education

DEDICATION

To my mom and dad for their unwavering support and love throughout all my educational endeavors and especially the long dissertation process. For reminding me that there is no "I" in team and that a person's achievements are in direct proportion to their efforts. I also want to thank the rest of my family members for their endless support, encouragement and understanding throughout the dissertation process: Elizabeth Bisset, Dr. John Hoy, Jack Hoy, Kristina Hoy, Davies Hoy, Andrew Bisset, Davies Bisset III, Megan Bisset, Molly Bisset, Lucy Bisset, Sophie Bisset, Bobby Bisset, Shaney Bisset, and Maeve Bisset.

ACKNOWLEDGMENTS

This study has been successfully completed with the support of many wonderful people who guided me along the way. I would like to thank Dr. Kevin Nugent, the chairperson of my committee, for his guidance and support throughout my graduate school career; Dr. Grace Craig for her continued support on the direction of the dissertation; Dr. Sangeeta Kamat and Dr. Sally Powers who offered their feedback and support; and Linda Guthrie and Sally Dumont for their assistance on the complicated procedures of the dissertation process.

I am indebted to the Jump Start participants and mentors for their willingness to participate in the study and make the work possible. To my colleagues on the Jump Start team, without their dedication and support this project would not have been possible. I would especially like to thank Sasha Bowers, my colleague and friend, for being the best co-project manager anyone could want. Dr. Dori Hutchinson, thank you for your warm support, encouragement and direction throughout the program and the dissertation writing process. And a thank you to the rest of the Jump Start team, particularly Matt Kuklentz, Donna Wilbur, Debbie Nicollelis, Cheryl Gagne, Larry Kohn, Dr. Leroy Spaniol, Kevin Berner, Dave Weene, Susan James, Ben Chicocki, Kerri Hamilton, Wendy Singleton, Charles Arena, Rona Gottfried, Jake Briggs, Dale Walsh, Marjorie Jacobs, Lyn Legere, and Lena Lawson.

Thank you to Jaffray Cuyler, Lori Wallace, Lisa DeAngelico and Dr. Courtney Harding, for their thorough reading of a myriad of drafts and for their support on many other levels of the writing process; Erin Dunn for being a great SPSS research consultant and statistical advisor; Peg Louraine for her technical assistance on the

formatting of the dissertation; Dr. Art Dell Orto, and my fellow graduate students' in Boston University's Doctoral Seminar for sharing their insights and thoughts on the dissertation process, especially my classmates and friends David Webster, Sui Ting Hsu and Amy Porter.

To Denise Kulawik, thank you for being my supportive and thoughtful friend throughout the whole process. To Erin McCoy for your conscientious feedback on my paper and for your unwavering support and friendship that helped me immensely. To Claire White and Kay Klausewitz, my fellow graduate students, thank you for sharing in the dissertation process all along the way. I would like to also thank Amy Twombly, Courtney Fitzgerald, Suzanne Fanous, Stacey Ward, Mary Alice Dombrosky and Leslie Reilly for being supportive friends throughout the entire dissertation process. To the members of my "Second Family," Pat, Terry, Jamie, Terry, and Maggie Moran for providing me with early insights into educational psychology in an applied setting that was loving and supportive! Thank you to my mentors, including Dr. Cathy Finn for being my first mentor in the dissertation process, and Linda Swardlick-Smith for connecting me to Boston University and for being a constant source of encouragement and energy. To Father Joseph Marchese for encouraging and guiding me to find a career path that included both satisfying and valueble work that contributes to the well-being of others. And a special note of thanks to a great teacher, Dr. Gilda Morelli, who introduced me to the concept of situated learning and whose hard work and dedication inspired me to strive to be an educator who "cares enough to make a difference."

ABSTRACT

THE ROLE OF EDUCATION AND SUPPORT IN THE VOCATIONAL DEVELOPMENT AND RECOVERY OF YOUNG ADULTS WITH PSYCHIATRIC DISABILITIES

SEPTEMBER 2004

KIMBERLY S. BISSET, B.A. BOSTON COLLEGE

M.A. BOSTON COLLEGE

Ed.D., UNIVERSITY OF MASSACHUSETTS AMHERST

Directed by: Professor Kevin Nugent

Young adults with severe psychiatric disabilities face many significant challenges that put them at risk for being able to transition into adult roles, some of which include: high unemployment rates, the low participation in postsecondary training and education programs, and a strong probability of remaining on public assistance after high school. These young adults also have impairments in the cognitive processing of forethought, planning, and risk assessment - yet most programs do not emphasize the necessary skills and experiences. The purpose of this study is to investigate participants' experiences with education and support to identify the factors that would facilitate their vocational development and recovery.

This study used a mixed method research design that involved both quantitative and qualitative measures. The study involved thirty-three participants from the Jump Start program, a career development and mentoring program that matched young adults ages16-26 with severe psychiatric disabilities with mentors who themselves have had a psychiatric disability. The central research instrument used was an open-ended semi-structured participant questionnaire. There were three quantitative measures that were

used: a Demographic Inventory, the Recovery Attitudes Questionnaire (RAQ-7) and the Interpersonal Support Evaluation List (ISEL). In-depth interviews were conducted with seven mentors from the Jump Start program to evaluate the mentoring relationship from their perspective.

The study found that many participants prefer specific and tangible learning activities that supported them in taking positive steps in their recovery. Results also showed that interaction with supports was a critical component of their vocational development and recovery. In particular supports involving place, professionals, family, staff and peers played significant roles for the participants. The research also demonstrated that the mentoring relationship made a difference in the lives of both the participants and the mentors.

Based on the findings, the researcher recommends three topics for further study. These include: 1) a longitudinal study with a larger sample as an examination of participants' experiences with education and supports; 2) a study designed to identify the variables, which foster young adults readiness to change their behaviors; and 3) a study that looks at what specific factors affects participants' ability to change their behaviors.

TABLE OF CONTENTS

LIST OF TABLES

Page

TABLE

CHAPTER 1

YOUNG ADULTS WITH SEVERE PSYCHIATRIC DISABILITIES

Introduction

Psychiatric disabilities disrupt the lives of approximately 5.5 million people in the United States (U.S. Surgeon General, 1999). Nationally, the unemployment rate for these individuals is alarmingly high at 85% (U.S. Surgeon General, 1999). The annual cost to the United States economy for individuals with psychiatric disabilities in both the public and private sector is $205 billion. One hundred and five billion of that original cost is due to lost productivity from rising rates of underemployment or lack of employment for individuals with psychiatric disabilities (Rice & Miller, 1998).

Young adults with severe psychiatric disabilities have the highest unemployment rates, the lowest involvement in postsecondary training and education programs, and the highest probability of remaining on public assistance after high school (Davis & Vander Stoep, 1997). In comparison to young people without psychiatric disabilities, young adults with severe psychiatric disabilities have more involvement with the criminal justice system, higher rates of pregnancy, an increased incidence of homelessness, and more problems with substance abuse as a result of the challenges they face during the transitional process (Davis & Vander Stoep, 1997). It is estimated that those young adults who enroll in Supplemental Security Income (SSI) early in their lives tend to remain in the system for an average of 27 years (NSCET, 2003).

Of the 18% of young adults experiencing psychiatric disabilities, the approximate number of young adults with *severe* psychiatric disabilities is 5-9% or between 2 million and 3.2 million young adults (Friedman, Katz-Levy, Manderscheid & Sondheimer, 1996). Since the fastest growing age group of the current population is youth between the ages of 16-26, there will be a rapid increase in the number of young adults with psychiatric disabilities (Davis & Vander Stoep, 1997). As a result, there is a growing need for specific services geared toward young adults with severe psychiatric disabilities, including educational and vocational skills and supportive training.

Statement of the Problem

The current mental health system provides inadequate support to young adults with psychiatric disabilities who are attempting to develop their educational and vocational competencies because the services do not focus on teaching the tasks that are critical to an adolescent's healthy transition to adulthood. Unfortunately, these developmental capacities are those most impaired by the experience of severe psychiatric disability in young adults (Vander Stoep, 1994). The system must change to better respond to these young adult lives that have the potential but not the capacity to transition independently to adulthood and self-sufficiency. Instead of developing a sense of self-reliance and embarking on an interesting career path, the participants without services may end up relying on the state and continuing the cycle of dependence. Therefore, young adults need supports to help them develop their skill deficits. They also need exposure to and experiences with real life situations in the community. Such experiences help to promote the development of supportive

relationships and assist young adults in successfully navigating life's challenges (Kastner & Wyatt, 1997; Bisset, 2000). In the current mental health system there are few resources to prepare these young adults for transition into adulthood. As the current system stands, these young adults will have little or no opportunity to be competitive in the current economy. Therefore, young adults are left to face adulthood with a myriad of skill deficits that all too often result in a downward spiral of poverty, crime, and chemical and system dependence (Davis & Vander Stoep, 1997; Blackorby & Wagner, 1996; Vander Stoep, Beresford, Weiss, McKnight, Cauce & Cohen, 2002).

Another disturbing trend is that rates of psychiatric disabilities are highest among certain ethnic populations. In the United States, Native American and African American young adults have the highest rates of severe psychiatric disabilities (Davis & Vander Stoep, 1997). Although Native American young adults were assessed as needing mental health services at a rate double than that of the general population, they are more likely to go without treatment than any other ethnic group. African American young adults with psychiatric disabilities, furthermore, are more likely to end up in the juvenile justice system than in a mental health facility (Vander Stoep et al., 1995).

The Significance of the Study

This study examined the participants' perceptions of their experiences with education and support and how it factored into their development and vocational recovery during one year. This study was unique because it explored the types and combinations of supports and education most helpful to participants in their educational and/or vocational goals. During a recent conference hosted by the National Center on

Secondary Education and Transition, educators suggested that "school to work transition programs do not typically focus on the skills and behaviors needed by youth with psychiatric disabilities to move beyond entry level employment and into lifelong learning opportunities and vertical (versus horizontal) career tracks" (Martinez & Stodden, 2003, p. 123). Consequently, young adults with psychiatric disabilities are rarely exposed to opportunities that develop experiences and skills needed to meet the demands of an increasingly competitive employment market.

Documentation on how integrated support systems can collaborate to create satisfying experiences of optimal functioning for young adults experiencing severe psychiatric disabilities is also scarce. Bond, Drake, Becker, and Mueser (1999) acknowledged that supported employment, supported education, and skill/support development contribute to successful vocational outcomes. Returning to work and school are two essential processes that can be critical aspects of recovery (IAPSRS, 2000). This study was also significant because it asks these questions directly to participants in both a quantitative and qualitative format that describes their individual and collective responses.

Significance of the Problem

Empirical evidence from the fields of psychology and psychiatric rehabilitation since the 1960's suggests that vocational education and training coupled with sufficient family, professional, and social supports can assist individuals with psychiatric disabilities to achieve long-term recovery and employment (Anthony et al., 2002). Despite this knowledge, the number of intelligent, educated, and motivated young

adults with psychiatric illnesses who remain unemployed is tremendously high. There is a clear gap between science and services as so many young adults with psychiatric disabilities are left in the precarious position of trying to surmount the barriers of unemployment alone.

What experiences or opportunities are these young adults engaged in to help them understand the responsibilities and risks of adult roles? There is no proper safety net, practice area, or support system for these young adults to gradually take on or learn adult expectations and commitments. In fact, many young adults with psychiatric disabilities have impairments in the cognitive processing of forethought, planning, and risk assessment, which further hinder their attempt to transition into adult roles (Davis &Vander Stoep, 1997). The critical question, therefore, is how do young adults successfully transition into adult roles? How can this transition take place without any educational, employment, skills training, or social experience supports to assist these challenges? There are so many barriers to independent adult functioning for young adults with psychiatric disabilities and too little or no supports to help them productively face them. How will this gap in services be appropriately addressed?

What are the specific factors of support and education that will help young adults with psychiatric disabilities make the successful transition into adult roles? How can the mental health system help to improve vocational and educational outcomes for young adults with psychiatric disabilities? What type or combination of vocational or educational supports will be most helpful? What elements of supported employment will be helpful- job searching skills, internship opportunities in community integrated settings, or mentoring? What types of supported educational opportunities will be

helpful-computer training, skills training, or daily living skills training? This study seeks to answer these questions.

Statement of Purpose

The aim of this study was to examine the different variables and levels of support and education needed to transition young adults with severe psychiatric disabilities into meaningful work and/or satisfying educational endeavors. The goal was to conduct interviews with the participants to understand their experience with education and support in the development and vocational recovery. Data was collected from a sample of young adults with severe psychiatric disabilities from the Jump Start Program at Boston University. The data was analyzed using quantitative and qualitative measures to answer the following research questions:

1. What are the participants' experiences with situated learning in their vocational development and recovery?

2. What are the participants' experiences with interacting with supports in their vocational development and recovery?

3. What are the participants' and mentors' experiences with the mentoring relationship in their vocational development and recovery?

Definition of Terms

Psychiatric Disability

Psychiatric Disability is defined as a health condition characterized by alterations in thinking, mood or behavior, or a combination of all three linked to distress and/or impaired functioning in a person (US Surgeon General, 1999). According to the

biopsychosocial model, which is generally accepted in the psychiatric community, most psychiatric disabilities are believed to have biological, environmental, and social components (American Psychiatric Association, 1994).

Severe Psychiatric Disability

Severe Psychiatric Disability is defined as a serious disturbance in thinking, perception, and behavior that leads to a diminished ability to function effectively in one of life's domains (IAPSRS, 2000). Anthony, Cohen, Farkas, and Gagne (2002) state, "persons with severe psychiatric disability have diagnosed mental illnesses that limit their capacity to perform certain tasks and functions (e.g., interacting with family members and friends, interviewing for a job) and their ability to perform in certain roles (e.g., worker, student)." There are three major categories of severe psychiatric disability. These three categories are schizophrenia, mood disorders, and anxiety disorders (including phobias, panic disorders and obsessive-compulsive disorders) (American Psychiatric Association, 1994).

Schizophrenia

Schizophrenia is characterized by disruptions in thinking, disorganized speech, and/or grossly disorganized or catatonic behavior. This psychiatric disability severely inhibits an individual's ability to relate to the world and those around him or her, a condition that can lead to periods of debilitating social and occupational dysfunction (American Psychiatric Association, 1994). Schizophrenia is a disturbance that lasts for at least six months and includes at least one month of active symptoms, which are

considered to be hallucinations, delusions, withdrawal, incoherent speech, and impaired reasoning (American Psychiatric Association, 1994).

Mood Disorders

Mood disorders include major depressive disorder and bipolar illness. Symptoms may include mood swings (such as feelings of extreme lows or euphoric highs), severe agitation or irritability, sleep and eating disturbances, and changes in levels of activity.

Bipolar Disorder

Bipolar disorder is defined as a disability of opposites. It is a mood disorder that combines the contrasting emotions of depression and mania (Whybrow, 1997). It is often called bipolar illness as opposed to the unipolar disorder of major depression (Whybrow, 1997). Individuals experiencing bipolar illness experience one or more manic episodes. A manic episode is a period of high energy, rapid thinking, and/or sleeplessness, often followed by a period of withdrawal, depression and/or suicidal thoughts (Whybrow, 1997; American Psychiatric Association, 1994).

Major Depression

Major depression is defined as a depressed mood most of the day, a diminished capacity or interest in pleasurable activities, significant weight loss, insomnia or hypersomnia, fatigue or loss of energy almost every day, feelings of worthlessness or

mislaid or extreme feelings of guilt, and a reduced capacity to process information or make decisions (American Psychiatric Association, 1994).

Anxiety Disorders

Anxiety disorders include phobias, panic disorders and obsessive-compulsive disorders. Anxiety disorders are the most common psychiatric disability (American Psychiatric Association, 1994).

Phobia

Phobia is defined as a clinical level of anxiety that is caused by an object or circumstance and leads to a level of avoidance that substantially interferes with the individual's level of daily functioning. Individuals with phobias experience extreme emotions of fear or peril from a particular object or situation.

Panic Disorders

Panic disorders are characterized by the experience of panic attacks. Panic attacks may involve sudden, intense feelings of terror without an acknowledged cause, and with physiological symptoms that feel like a heart attack (American Psychiatric Association, 1994). Symptoms of a panic attack include shortness of breath, heart palpitations, discomfort in the chest, sensation of feeling smothered, or fear of losing control or state of mind.

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder is characterized by obsession, which causes marked anxiety or distress and/or by compulsion, which serves to alleviate anxiety. For example, individuals with obsessive-compulsive disorder try to alleviate their anxiety by repeating words or phrases or engaging in repetitive, ritualistic behaviors such as hand washing (American Psychiatric Association, 1994).

Psychiatric Rehabilitation

Psychiatric rehabilitation is an approach of assisting individuals with long-term psychiatric disabilities to increase their functioning so that they are able to be in their preferred environments with a minimal amount of professional provisions (Farkas & Anthony, 1989). Two significant ways this aim is fulfilled is either through developing the specific skills the person needs to perform effectively and/or developing the supports needed to enhance functioning. Psychiatric rehabilitation focuses not on past causes or intrapsychic processes, which is a common practice in psychotherapy, but on current skills and future goals. Although psychiatric rehabilitation does take into consideration the past as it is relevant to the individual's current situation, the professional's main energies are not dedicated solely to understanding the individual's past. Psychiatric rehabilitation develops the person's strengths, focusing on the individual's assets in a way that develops their existing competencies to successfully participate in the community (Anthony et al., 2002). In contrast, many clinical psychiatric treatments of individuals experiencing severe psychiatric disabilities are based on the medical model. The medical model focuses more on the pathology of the

person, with the goal of reducing the individual's symptoms through medical interventions (Anthony et al., 2002).

Young Adults

Young adults are defined as individuals between the ages of 16-26. This definition is connected to both their individual level of development and to the provision of service. Before the age of 18, young adults are labeled as having serious emotional disturbance. After turning 18, they are then diagnosed as having a psychiatric disability (Davis & Vander Stoep, 1997). Because almost all of the participants' in the program are over eighteen, the term severe psychiatric disabilities will be used for the purposes of this paper (Costello, 1989; Davis & Clark, 2000).

Educational Support or Supported Education

Educational support or supported education is defined as a unique application of psychiatric rehabilitation for individuals with psychiatric disabilities who are trying to introduce or reintegrate education into their lives. The mission, goals, and principles of supported education are rooted in the foundation of psychiatric rehabilitation and educational psychology. The mission is to help participants to choose, get, and keep a desired education.

Supported Employment

Supported employment is defined as an "individualized instruction and support program, which assists individuals with psychiatric disabilities to obtain job goals. The

goal of these services is to help participants choose, get, and keep a job in which they feel satisfied and successful" (Anthony, Howell & Danley, 1984, p. 76). Similarly, psychiatric vocational rehabilitation is defined as helping people with severe psychiatric disabilities to choose, get, and keep the job or educational opportunities they prefer, in a productive and healthy work environment where they are paid equitably for their efforts (Anthony, Cohen, Farkas & Gagne, 2000; Sullivan, Nicolellis, Danley & MacDonald-Wilson, 1994.)

Family

Family is defined as any significant person in a young adult's life, including nuclear family or extended family, without limitation by any legal or biological definition of family. This distinction is made according to the participant's determination of the level of importance of this person to his or her life. Family support is defined by Liberman, Kopelowicz, Ventura, and Gutkind (2002), as involving acceptance, warmth, understanding, encouragement, a caring approach toward progress, and positive encouragement.

Recovery

Recovery is defined as the process of empowering individuals with hope and self-esteem to "recover" valued social roles and find new meaning and purpose in their lives. Recovery is not defined as curing severe psychiatric disabilities (Anthony et al., 2002). Instead it emphasizes learning to work within the limits of the disability.

Meaningful Work

Meaningful work is defined as tasks that an individual determines as successful and satisfying. Meaningful work, an essential component of the recovery process, was described as one of the functional indicators of healing and growth beyond the disability, and is seen as invaluable in recovering a personal sense of self-worth (Bond, 1996; Deegan, 1997; Spaniol, Gagne & Koehler, 1999; Spaniol, Koehler & Hutchinson, 1994).

Jump Start

Jump Start is the location for the research study. Jump Start is a holistic educational program that helps young adults with severe psychiatric disabilities identify their needs and develop appropriate skills for their recovery processes. The Jump Start Program is part of the Services Division of the Center for Psychiatric Rehabilitation at Boston University. Courses were conducted in a university setting that enhances participants' self-esteem and sense of community. The Center believes that recovery relies heavily on a shared community, where individuals can articulate personal success strategies. Jump Start is a demonstration project funded by the National Research Services Administration. Skill development and community integration are two of the cornerstones of the Jump Start program. Young adults with psychiatric disabilities want to have the same "normal" experiences of growing up as their peers--completing school, finding a job, making friends--but often lack the skills, supports, and opportunities to do so. Jump Start not only tries to address the "normative" issues young people face, but also the unique needs of young people at various stages in the process of coming to

terms with having a severe psychiatric disability. Please see Appendix C for a more detailed description of the Jump Start program.

Program Participation

Program participation is defined as any level of contact with the program. Participants had the opportunity to partake in the program on various levels, and to receive supported employment services from both staff and mentors. The four different ways of participant involvement were: 1) to have a mentor and meet with him or her weekly; 2) to participate in career development, wellness, and/or computer training classes; 3) to have individual meetings with staff on career or personal development issues; and 4) to attend social events. Due to high rates of attrition in these types of programs and taking into consideration the extremely diverse needs and preferences of the young adults, the program allowed participants to choose which services best met their needs.

Participant Participation

Participant participation is defined as being in contact with a mentor either by phone or through individual meetings, attendance in one or all of the classes, or just interacting with a particular staff person with whom they have formed a connection. The program maintained that it was important to acknowledge and respond accordingly to the participants' capacity to be engaged in the program. Therefore the participants were able to customize and optimize the services they chose.

Situated Learning

Situated learning is a theory that maintains that passively receiving knowledge 'transmission' is not a valid form of learning because the person is not situated in a relevant context, engaged in an activity, or belonging to a group (Lave & Wagner, 1991). This theory was applied throughout the Jump Start program because the participants were actively placed in an interactive classroom, educational, or employment setting. The participants did not idly sit and absorb the material; they were challenged to participate as well as create the situations, or at least the groundwork, for the opportunities that they sought. Examples included: mock interviewing or role playing, community service activities, social events, volunteer opportunities, internships, and jobs to develop their competence and their self-confidence.

Summary

This chapter highlights many of the significant problems facing young adults with severe psychiatric disabilities; some of which include: high unemployment rates, the lowest participation in postsecondary training and education programs, and the strongest predictors of remaining on public assistance after high school (Davis & Vander Stoep, 1997). Young adults with psychiatric disabilities have impairments in the cognitive processing of forethought, planning, and risk assessment; yet most programs do not emphasize the skills and experiences necessary for their development and vocational recovery. This puts them particularly at risk for being unable to transition into adult roles (Davis &Vander Stoep 1997; Martinez & Stodden, 2003).

Given such challenges facing the development and vocational recovery of participants, this study's aim was to determine the specific factors of support and education that assisted participants in making a successful transition into adult roles. This research also sought to evaluate the effects of situated learning, the mentoring relationship, and interactions with supports on the development and vocational recovery of participants. Although this study has some small program evaluation components, the main focus was to determine the answers to the research questions from the participants' perspectives using semi-structured interviews with open-ended questions to capture their lived experience. The participants' perspective on the role of support and education in their development and vocational recovery have been coded for themes and analyzed and will be conveyed primarily using the participants own words.

Overview of the Following Chapters

The next chapter provides an overview of the historical, political, social, and cultural influences on the field of psychiatric rehabilitation. The four main categories in psychological theory that shaped psychiatric rehabilitation will also be detailed. Next the three significant ideas in psychiatric rehabilitation: recovery, supported employment, and supported education, referencing important empirical evidence that demonstrates these prominent roles in the literature and provides the foundation for the present study will be explored. Chapter 3 explains the methodology of the study, paying careful attention to the qualitative research process. The qualitative research component uses an open-ended semi-structured interview survey to capture the participants' experiences and perceptions on supports and education that will enhance

their development and vocational recovery. Chapter 4 synthesizes the themes extracted by participant interviews and organizes them according to the research questions. Quotes are examined to better understand the meaning-making process of participants' experiences. The mentors' perspectives on the mentoring process are also outlined. Chapter 5 discusses and summarizes the Results Section, further elaborating on the meaning and significance of the participants' and mentors' perspectives and how they tie into the theoretical frameworks and components of psychiatric and empirical research that have shaped psychiatric rehabilitation. Chapter 6 examines the significance to and implications of the research on the systems, programs and people involved in psychiatric rehabilitation.

CHAPTER 2

REVIEW OF THE LITERATURE

Introduction

This chapter will first explain the historical, political, social, and cultural influences on the field of psychiatric rehabilitation. It will also describe the ways in which the four main categories of psychological theory shaped psychiatric rehabilitation. These categories include the analytic approach or insight theories, experiential and relationship-oriented theories, action theories, and contextual theory. Next, the three significant ideas in psychiatric rehabilitation will be explored: recovery, supported employment, and supported education, referencing important empirical evidence that demonstrates their prominent role in the literature.

The Historical, Political, and Social Evolution of Psychiatric Rehabilitation

Anthony, Cohen, Farkas, and Gagne (2002) state that psychiatric rehabilitation, which evolved out of psychosocial rehabilitation, has developed at different points in time throughout the world. In Europe it started with social psychiatry in the 1930s (Van der Veen, 1988; Basaglia, 1982). Psychiatric rehabilitation also has its roots in physical disability. The field arose partly out of the need to respond to disabled veterans of WWI and WWII (Basaglia, 1982; Saraceno & Togonomi, 1989). It further developed as a result of responding to the industrial accidents in an urbanizing America (Saraceno & Togonomi, 1989). Psychosocial rehabilitation is a holistic approach that places the individual, not the psychiatric disability, as the focal point of the intervention (IAPSRS,

1994). Hughes, Woods, Brown, and Spaniol (1994) state that the major objective of psychosocial rehabilitation is to restore each individual's capacity for independent living, socialization, and effective life management. The International Association of Psychosocial Rehabilitation Services states, "psychosocial rehabilitation focuses on 'real world' everyday activities and facilitates the development of skills and supports for people to participate as fully as possible in normal roles within family and community settings" (IAPSRS, 1994, p. 223).

The beginnings of psychosocial rehabilitation originated with social clubs in the 1930's and programs for people with psychiatric disabilities in England and the Soviet Republics (Rutman, 1987). The idea of providing an accepting and supportive environment for individuals with severe psychiatric disabilities evolved during the 1940's when the field began to look for alternative care options and settings outside of psychiatric hospitals (Hughes, Lehman & Arthur, 1996).

The Significance of the Moral Therapy Era on Psychiatric Rehabilitation

One of the most significant historical influences on the development of psychiatric rehabilitation was the moral therapy era that began in the 1800's (Anthony et al., 2002). During the 19th century, moral therapy began the shift from the punitive treatment of individuals who experienced severe psychiatric disabilities to rehabilitative treatment policies. Moral therapy was defined in this era as "compassionate and understanding treatment of innocent sufferers" (Barlow & Durand, 2002). The treatment and rehabilitation practices were greatly improved during this time. Mental institutions began removing psychiatric patients from criminally established jails and

prisons into new institutions. These new institutions began initiating humanitarian measures by eliminating harsh, punitive actions like seclusion and restraints (Barlow & Durand, 2002). Moral treatment stressed a holistic assessment of a person with a psychiatric disability, taking into consideration all aspects of an individual's well-being. Moral treatment also recognized that structured activity is more therapeutic and has more value than verbal therapy. The early 19th century moral therapists were significant because they used several treatment principles that became part of valued psychiatric rehabilitation practice. These included treating the person not the illness, building upon the abilities of the individuals; not classifying individuals by their disabilities; and acknowledging that individuals do have the capacity to improve their current conditions (Anthony et al.., 2002). French psychiatrist Philippe Pinel implemented moral therapy as a systemic approach in the treatment of individuals with mental illness in the 1790s (Barlow & Durand, 2002). Pinel established a humane, socially facilitated environment within an institutional setting. The treatment included encouragement and understanding, as opposed to more aggressive methods. Pinel promoted purposeful work as a therapeutic intervention (Barlow & Durand, 2002).

During this time, English merchant and philanthropist William Tuke founded the York Retreat (Barlow & Durand, 2002). This institution provided compassionate and intellectual treatment for individuals with severe mental illness. Likewise, in the United States, Benjamin Rush introduced moral therapy at Pennsylvania Hospital. Along with medications, he endorsed nutrition, exercise, and the upkeep of personal appearance when treating individuals with psychiatric disabilities. In 1833, Horace Mann, Chair of the Board of Trustees, implemented moral therapy at Worcester State

Hospital (Barlow & Durand, 2002). A new environment was created, consisting of individualized care, occupational therapy, religious exercises, and social activities. Pinel and Tuke sought an "elevation and reorganization of patient's mental processes" through philosophy, music, art and literature (Barlow & Durand, 2002).

In 1841, Dorothea Dix began her campaign to improve the conditions and treatment of individuals with psychiatric disabilities (Barlow & Durand, 2002). Mental institutions that provided humane treatment were scarce; therefore, many individuals resided in prisons, poorhouses, or on the streets. Dix persuaded the legislature to appropriately fund and increase the establishment of growth promoting mental asylums (Barlow & Durand, 2002). Unfortunately, starting in the mid-19th century, moral therapy and the humane treatment of individuals with mental illness greatly declined (Anthony et al., 2002). As the number of individuals institutionalized increased, moral therapy became less effective due to the rapid influx of patients combined with inadequate staffing. Therefore, moral therapy was discarded for custodial care. The growth and health promoting mental health system of care was abandoned because it was economically unfeasible to care for so many individuals experiencing psychiatric disabilities. Once it was discovered that psychiatric disability had a genetic component, moral therapeutic treatment or intervention was thought to have less of an impact.

The Legislation Influencing Vocational Rehabilitation

Another relevant historical development was the inclusion of individuals with psychiatric disabilities into state vocational rehabilitation programs. As a result of the 1943 amendments to the Vocational Rehabilitation Act, originally created for the

rehabilitation of individuals with physical disabilities, individuals with psychiatric disabilities became eligible for financial support and vocational rehabilitation services. The amendments gave greater credence to the idea of rehabilitating individuals with psychiatric disabilities and focused the field on improving vocational skills (Anthony et al., 2002). Psychiatric disabilities are now the second most frequent category of disorders in the state vocational rehabilitation system (Stoddard et al., 1998). Although psychiatric rehabilitation's focus was primarily on vocational outcomes over the past few decades, the emphasis has now shifted to include all aspects of development including living, learning, and social environments.

Psychosocial Rehabilitation Centers

Grob (1983) and Rutman (1987) traced the origins of psychosocial rehabilitation centers to early clubhouses. Groups of ex-patients founded the early centers such as Fountain House and Horizon House for the purpose of mutual aid and support. It was believed that the values of socialization and community inclusion that Adler (1937) espoused in his therapy contributed to the development of the first clubhouse, Fountain House, founded in the 1950s in New York City (Beard, Propst & Malamud, 1982). Operating outside the mental health system, it became known as a "clubhouse" because the activities revolved around a central meeting house for the "members" to gather and socialize. The clubhouse model was based upon the idea that in order to be considered a contributing member, everyone must take an active role that adds value to the organization. The clubhouse was organized and operated by consumers of the mental health system who took responsibility and ownership of the space (Beard et al., 1982).

The clubhouse hours also operated during hours that resembled business hours versus those of psychiatric hospitals or institutions. These social clubs were the foundation for the early comprehensive, integrated service psychosocial rehabilitation centers such as Thresholds in Chicago, The Center Club in Boston, Portals House in Los Angeles, and the Social Center for Psychiatric Rehabilitation in Fairfax, Virginia. Since their inception, these centers have stressed health promotion rather than symptom reduction, which is a central philosophy of psychiatric rehabilitation (Leitner & Drasgow, 1972). One of the core principles upon which these centers operate is that individuals with severe psychiatric disabilities have the capacity to be productive (Beard et al., 1982). These centers do not place a high value on development of therapeutic insight achieved through verbal therapies (Dincin, 1981). Rather the focus of the clubhouse is on helping individuals successfully navigate their current environment (Grob, 1983).

Vocational activity is also a central ingredient in the Fountain House model of psychosocial rehabilitation centers (Beard et al., 1982). In both clubhouses and psychosocial rehabilitation centers, the philosophies of psychiatric rehabilitation are effectively utilized through the improvement of individual competencies. The roles and responsibilities that a member takes on at the clubhouse are meant to prepare that individual to utilize those skills in an employment opportunity in the community. As one member leaves his or her temporary job at the clubhouse for a competitive employment position, a new member of the clubhouse takes over that job in order to enhance his or her skills. In this way, temporary employment positions help individuals with psychiatric disabilities best prepare themselves for employment and community integration.

Psychosocial rehabilitation centers are places where the philosophy of psychiatric rehabilitation is enhanced and further developed. The establishment of the clubhouse was significant to psychiatric rehabilitation because it was one of the first psychosocial rehabilitation centers to provide the psychiatrically disabled with a valued role. In this role, members are held accountable for the center's operation, which models the values of peer involvement and partnership. These values are crucial cornerstones in the development and practice of psychiatric rehabilitation (Anthony et al., 2002). They did not, unfortunately, carry over sufficiently into the Deinstitutionalization Movement in the 1950's and the 1960's.

Causes and Ramifications of Deinstitutionalization

Two simultaneous occurrences in the 1950s and 1960s led to the discharge of thousands of patients from mental hospitals into the community. This was known as deinstitutionalization (Stroul, 1986). The first occurrence was the introduction of psychotropic medications, which were developed to effectively control the severe symptoms of psychiatric disabilities. The development of these "wonder drugs" contributed to the shift away from treating and housing individuals with severe psychiatric disabilities in large psychiatric hospitals. The new medications offered the first possibility of hope that individuals with psychiatric disabilities could function outside the hospital environment (Stroul, 1986). The second occurrence, the Community Mental Health Act of 1963, also influenced deinstitutionalization through the allocation of federal funds, which were authorized for the creation of comprehensive mental health centers. These mental health centers promised to help transition the locus

of care for individuals experiencing psychiatric disabilities from hospitals to communities. In the past forty years, there has been a deliberate effort to deinstitutionalize individuals with severe psychiatric disabilities who have been hospitalized. Approximately 90% of individuals in long-term psychiatric institutions (900,000 individuals) have been discharged into the community since the 1960's (Torrey, 1995). Unfortunately, in many cases, the money and resources promised to help individuals with psychiatric disabilities transition into the community never fully materialized.

As a result of deinstitutionalization, the burden of supporting individuals with psychiatric disabilities fell more heavily on other social services. The influx of these individuals into both state and federal vocational rehabilitation systems and the Social Security disability system since the 1960's, has made the assessment of their capacity to work a pivotal issue (MacDonald et al., 2001). Since the concept of vocational rehabilitation was first introduced into the mental health system, it has been extremely difficult to accurately assess employment potential (MacDonald et al., 2001). Historically, the Social Security Administration relied upon evaluation of a person's medical impairment, but numerous studies have failed to establish a conclusive relationship between measures of psychiatric diagnosis or symptoms and work outcomes (MacDonald et al., 2001).

Creation of Community Mental Health Centers

The Community Mental Health Act of 1963 created community mental health center's (CMHC's) to develop more humanizing and cost-effective alternatives to

institutionalized care in order to meet the comprehensive needs of individuals with psychiatric disabilities (Bassuk & Gerson, 1978). The Act was based on the guiding principles that all individuals with psychiatric disabilities should be treated in the least restrictive environment possible within their own community (Stroul, 1986). The challenge of realizing this goal of community integration was two-fold. First and foremost, the amount of money was not adequate to create enough centers to accommodate the number of individuals being discharged from hospitals. In addition to the lack of facilities, there was also a significant lack of trained professionals. The majority of community mental health workers were trained in only traditional medical model mental health treatment techniques and did not possess the knowledge or skills to help facilitate the community integration of this population (Farkas, O'Brien & Nemec, 1988). Mental health workers were trained to medicate and restrain individuals with psychiatric disabilities and knew very little about how to best prepare them to function successfully in a new community. Initially, many deinstitutionalized individuals were deemed inappropriate for services in settings such as community health centers. This occurred despite the fact that there was an allocation of federal funding for community mental health centers specifically designated for this population. Workers trained in psychodynamic therapy sought to provide individual psychotherapy for persons with severe psychiatric problems but tended to classify them as unresponsive to treatment (Pratt et al., 1999). As a result of this lack of preparation on the part of the community mental health centers, individuals with severe psychiatric disabilities became increasingly isolated and remained underserved in the community (Pratt et al., 1999).

Torrey (1995) asserts that only 5% of the 789 federally funded community mental health centers accepted the challenge of providing appropriate services to this deinstitutionalized population. Little or no training was taking place in the mental health field to better help professionals respond to the needs of individuals with severe psychiatric disabilities. Although the CMHC's were not able to meet the needs of these individuals, the CMHC's concept of local treatment and support in the individual's community is central to psychiatric rehabilitation (Anthony et al., 2002). CMHC's practice of immediately responding to a person's crisis in his or her own environment and only removing the individual when absolutely necessary, for the shortest amount of time possible, is a psychiatric rehabilitation principle as well (Anthony et al., 2002).

Evolution of Community Support Programs

The need for improved rehabilitation services was clearly demonstrated by the ramifications of the deinstitutionalization movement (Anthony & Farkas, 1989). In the 1970's, the National Institute of Mental Health began to confront the problems of the CMHC's in a systematic way (IAPSRS, 1994). In 1977, the Government Accounting Office (GAO) issued a report that was critical to deinstitutionalization (Rutman, 1987). This report provided a plan to be more responsive to individuals with psychiatric disabilities (IAPSRS, 1994). The National Institute of Mental Health established the Community Support Program (CSP) in 1978 to provide services based on the rehabilitation model. The CSP's provided funding to states to develop more integrated community programs that encouraged increased quality of life and functioning for individuals experiencing psychiatric disabilities. Eleven essential areas for

improvement were proposed: identification and outreach to individuals with psychiatric disabilities, mental health treatment, crisis response services, health and dental care, housing, income support and entitlements, peer support, family and community support, rehabilitation services, protection and advocacy, and case management (Stroul, 1994).

Examining the Personal and Political Impact of Deinstitutionalization

There were emotional, intellectual, social, and political ramifications of the deinstitutionalization movement. Individuals with severe psychiatric disabilities constitute one of the most rejected, stigmatized, and disadvantaged populations in the United States (Deegan, 1996; Chamberlin, 1984; Gagne & Kramer, 1997). The issue of psychiatric deinstitutionalization remains a significant social problem.

Institutionalization had negative behavioral and health effects. Specifically, long-term stays in institutions, whether state or private psychiatric hospitals, hindered the overall well-being of individuals with severe psychiatric disabilities. One of the most common outcomes for the psychiatrically disabled was extreme dependency on their care providers (Rutman, 1987). This level of dependency results from the practice of hospital staff frequently controlling every aspect of their patient's lives. Other side effects of long-term psychiatric hospitalization include compliancy; apathy; loss of self respect; depersonalization; feelings of powerlessness; problems maintaining social, family, and community relationships; and a high susceptibility to stress (IAPSRS, 1994). Therapists and psychiatrists can sometimes perpetuate this level of dependence by being the "experts" about a person's life and not encouraging the person to take ownership of their own choices and actions.

Politically, the Civil Rights Movement, which spawned the women's movement and the consumer movement, also influenced the development of psychiatric rehabilitation. The New York Work Exchange developed a task force to explore how to improve the employment and educational outcomes for individuals experiencing psychiatric disabilities. The New York Work Exchange concluded that individuals with psychiatric disabilities have the same rights and responsibilities as other citizens. In order to promote self-determination and self-sufficiency for this population, the saying "Nothing about us without us" was created (Pratt et al., 1991). This phrase epitomizes the opinion that individuals with severe psychiatric disabilities deserve a voice in their own treatment and in the creation of policies that affect their treatment.

It was the individuals with severe psychiatric disabilities themselves who were personally committed to making a change in the way they were treated. The "consumers", a term that is short for consumers of mental health services, which included but was not limited to hospital utilization, medication, and therapy, are part of the "ex-mental patient" movement. This movement is an organized effort by people with severe psychiatric disabilities to advocate for civil rights and humane treatment approaches. This national movement also has provided access to a variety of self-help and alternative treatment approaches. The consumer/survivor movement began to garner influence in the mental health field in the 1980's and has had a significant impact on the development of psychiatric rehabilitation (Chamberlin, 1984; 1989; 1990). In the 1990's, the consumer leaders of the psychiatric rehabilitation movement wrote and published powerfully persuasive pieces about their own experiences and a wide range of

consumer/survivor issues (Chamberlin, 1984; 1989; 1990; Deegan, 1988; 1992; 1996; Fisher, 1994 & Zinman, 1982).

Some of the early consumer/survivor organizations included groups such as We Are Not Alone, Mental Patients Liberation Front, Mental Patients Rights Association, and Network Against Psychiatric Assault (Zinman, 1982; Chamberlin, 1990). The Independent Living Center movement has also contributed a substantial amount to advancing peer support, self-help, self-determination, and individual and system advocacy for individuals with severe impairments (Weinstein, 1994). In 1979, people who desired to assist their family members with psychiatric disabilities, as well as themselves, created the National Alliance for the Mentally Ill (NAMI) in Madison, Wisconsin (Pratt et al., 1999). NAMI describes itself as a "grass roots, self-help, support, and advocacy organization for families of people with serious mental illness, and those persons themselves" (NAMI, 1996; 1998). NAMI's mission is to provide mutually beneficial and informative support, public education, and to increase advocacy efforts and legislative outcomes for individuals with psychiatric disabilities and their families. Although grassroots efforts are monumentally important to the cause, it is also critical to have legislative support to ensure the rights protection of individuals with psychiatric disabilities on the national level. The National Empowerment Center (NEC) was created from this movement (IAPSRS, 1994). It provides information, technical assistance, and a national directory of mutual support groups, drop-in centers, and statewide organizations that promote recovery, empowerment, and hope and healing (IAPSRS, 1994). The NEC's essential belief is that there is the possibility of recovery for even the most severely mentally ill.

The Americans with Disabilities Act is also a significant development in psychiatric rehabilitation and will be addressed later in the supported employment section. In psychiatric rehabilitation, the history and the theory happen concurrently, yet not necessarily in conjunction or collaboration with one another. As a result, this paper will now examine the theoretical underpinnings of psychiatric rehabilitation in the four most significant categories: the analytic approach or insight theories, experiential and relationship-oriented theories, action theories, and contextual theory. Each theory will be defined, its benefits will be stated, and its influence on psychiatric rehabilitation will be explained.

Theoretical Underpinnings of Psychiatric Rehabilitation

Analytic Approach and Insight Theories

When examining the impact of psychoanalytic theory on psychiatric rehabilitation, it is important to note its limitations on the therapeutic relationship. Psychoanalytic theory focused on one's inner thoughts rather than on a behavioral approach to change. In the treatment of severe psychiatric disabilities, this form of psychotherapy has been found to be generally ineffective (Lieberman, 1997). Freud (1936) considered an individual in therapy to be a lifelong client who would explore his or her past indefinitely. This model focuses on biological and instinctual factors, but does not adequately take into consideration social, cultural, and interpersonal influences.

Although Freud's approach to therapy was entirely "physician directed," in direct contrast to the person-centered model of psychiatric rehabilitation, he is credited for his contribution to all types of therapy, and for establishing the interview as a recognized therapeutic measure (Raskin, 1948). Freud's work is also important to the field of psychiatric rehabilitation because he created theoretical constructs that led to greater understanding of the human condition and established the foundation for many concepts in therapy (Raskin, 1948). Freud also believed that employment was essential to an individual's mental well-being. Freud (1930) stated that

> … work has greater effect than any other technique of living in the direction of binding an individual closely to reality; in his work at least, he is securely attached to a part of the reality… the human community. (p. 69)

Otto Rank broke away from classical Freudian theory after being Freud's student. Rank believed that the collaborative relationship of the professional therapist and client was a valuable part of the therapeutic process. In his work, Rank (1941) emphasized the importance of the current experience and the full expression of the client's feelings in therapy. Unlike Freud, Rank (1941) felt that a person was a valued participant in the therapeutic process, not simply a client receiving directions about how to live life. Believing that it was crucial for the client to learn to like him or herself, Rank (1968) used "will therapy" to help clients achieve their true level of personal vitality. Rank's (1968) will therapy maintained that clients have the capacity to grow and change in the context of the therapeutic relationship. Deviating from Freudian theory once again, Rank (1968) believed that therapy should be time-limited. He believed that once an individual worked through an issue, he or she could end the therapeutic relationship.

Rank's (1941) greatest contributions to the field of psychiatric rehabilitation were the emphasis he put both on the therapeutic relationship and on the importance of humanizing the therapist. Rank (1941) was concerned about the interpersonal rapport-building capacities of the therapist, not the therapist's technical skills in solving human problems. In the 20th century, Rank's (1941) theories sparked many ideas later developed by the leaders of psychiatric rehabilitation; such as Rogers, Carkhuff, and Truax.

Building upon many of Freud's development theories, Erik Erikson (1963) constructed his view to include psychosocial aspects of development beyond Freud's narrow scope of early childhood. Erikson (1963) maintained that psychosexual growth and psychosocial growth take place together, and that during each stage of life individuals are challenged with the task of reconciling inner selves with the greater social environment. Erikson (1975) believed that significant developmental challenges exist throughout one's life cycle, not just in childhood as psychoanalytic theory suggested. Personality develops, according to Erikson (1963), along pre-established benchmarks, and society is structured to encourage challenges that arise during these stages. As one matures, new skills are acquired resulting in new possibilities, as well as increasing societal demands on one's functioning. In a further departure from Freud, Erikson recognized the effects of society, history, and culture on personality. He saw each stage as a conflict between the person and the environment. Erickson maintained that the person was faced with a choice to resolve the conflict productively or in a maladaptive way. According to Erikson (1963), a positive resolution caused a change that gave an individual the strength to face the next crisis or stage. Individuals unable

to resolve the conflict at a certain stage were confronted with the struggle later in life. Erickson (1963) believed that unresolved conflicts accumulated and as a result hindered or halted an individual's development.

Erikson's development theory (1982) created a broader perspective to the idea of maturation and progressive learning potential over the lifespan of an individual. He brought a more optimistic sense that individuals were not trapped by their childhood challenges or dilemmas and could work through issues and acquire new skills throughout their lives (Erikson, 1982). This perspective on the learning potential of individuals with psychiatric disabilities is widely used in the psychiatric rehabilitation field today.

Experiential and Relationship-Oriented Theories

Experiential and relationship-oriented theories stress what it means to be fully human. Existentialists and person-centered theorists are part of this category. Although there are many existentialist thinkers who influenced the development of this field, Rollo May is highlighted because of his impact on psychiatric rehabilitation. May (1967) emphasized freedom of choice, responsibility, and self-determination. May felt that people should be concerned with broader questions of existence rather than on utilizing technical or behavioral approaches to confront life's challenges. May (1967) characterized one's existence as evolving and never stagnant. Rejecting the deterministic view of human nature, May (1967) developed a more philosophical approach to understanding one's present experiences. May (1950) refused to reduce therapy to a series of techniques. May (1961) acknowledged men and women as human

beings rather than patients and sought to understand the complex processes of human experiences. His philosophy was based on individual respect and appreciation of the idea that our lives are continually evolving. He believed that the therapist should help clients focus on ways to improve society as a whole. Like Alfred Adler, May believed that individuals should develop their social interests in order to be more responsive to societal needs. Thus, the goal of therapy is to help clients take actions based on the authentic and purposeful meaning in their lives (May, 1950). Existentialism challenges individuals to come to terms with their own isolation and fear of death and live life authentically. Through this process of acceptance, May (1981) believed that the person could acknowledge and accept the freedom and responsibility that comes with becoming the person that he or she was capable of being. May (1981) maintained that only through the acceptance of death could we fully embrace life.

The existentialist theory values the interpersonal relationship between client and therapist. This value laid the foundation for many of the major principles in psychiatric rehabilitation. Existential theory is important to the field of psychiatric rehabilitation because it espouses the core concepts of self-determination, personal choice, and responsibility upon which psychiatric rehabilitation is built. Moreover, it rejects the deterministic view of human nature and proposes a philosophical approach to understanding one's present experiences and behaviors.

A second theory within the experiential and relationship-oriented theories is person-centered theory. The humanist Carl Rogers is a founding father in the field of psychiatric rehabilitation. In the 1940's, he originated the concept of person-centered therapy, a substantial departure from traditional psychoanalytic therapies (Rogers,

1959). Person-centered therapy is not a cohesive package of techniques; it is founded on responsiveness to an individual's needs in the moment.

Rogers (1959) believes that the client and therapist should be in communication together, and the establishment of a strong connection is necessary for a successful therapeutic relationship. Rogers (1942) was the first therapist to use the term "client" instead of "patient". Client-centered therapy is now referred to as person-centered therapy or non-directive therapy. Person-centered therapy accentuates one's conscious sense of self and helps resolve conflicts in personal growth. Rogers believes that the client should direct the flow of therapy, not the therapist. He believes that the client is responsible for shaping his or her own future by taking the personal responsibility to actively make choices toward his or her self-articulated goals.

Rogerian therapy (1951) focuses on experiencing the present moment, learning to accept oneself, and deciding on ways to change. This therapeutic approach is based on a genuine, respectful, and empathic relationship between the client and practitioner (Rogers, 1957). Empowerment in therapeutic process is relevant to one's potential for growth, wholeness, spontaneity, and inner-directedness (Rogers, 1961). The Rogerian person-centered approach is to help the client solve the problem (versus the counselor) and help the client strive toward greater independence and integration. The focus is on the individual, not on the problem. Rogers (1959) believes that individuals have the potential to solve their own problems. This therapy also places more emphasis on the emotional elements of the situation rather than on the intellectual aspects. Greater importance is placed on the client's immediate situation rather than on the client's past. It also focuses on the therapeutic relationship itself as a growth experience.

Rogers' emphasis on the therapeutic relationship has been widely incorporated into the field of psychiatric rehabilitation. Rogerian therapy, however, can be problematic under the care of a therapist who is passive and simply minimizes his responses to reflecting back what the client has stated. Also, many clients actively seek out more direction, more structure, and more feedback than what is put forth in this therapeutic process. Individuals in crisis also may require more intervention, advice, and practical solutions than they may have the capacity to directly apply to their life on their own. The most noted critique of his work was that there is little or no clinical research or evidence base that demonstrates that Rogers' therapeutic interventions actually helped people get better. Many critics of Rogers state that he does not appropriately take into consideration an individual's personal history, which is a vital part of the developing person. To ignore major parts of an individual's past or to de-emphasize their relevancy may lead to the discounting of major pieces of a person's life.

Cognitively and Behaviorally-Orientated Action Theories

The third major category of theories relevant to psychiatric rehabilitation is the cognitively and behaviorally oriented action theories. The most significant of these theories is behavioral theory. Behavioral therapy works to change what individuals are doing and thinking using an action-orientated approach and cognitive processes that are derived in psychological research. Similar to psychiatric rehabilitation, behavioral therapy rejects the traditional intrapsychic therapeutic process and the medical model of behavior, both of which focus mostly on the illness, not on the individual. Behavioral

therapy is short-term and task-orientated, and does not focus on an individual's past or current feelings.

Three significant figures in behavioral therapy are Joseph Wolpe, Alfred Adler, and Albert Bandura. Wolpe, the founder of the behaviorist school, believed that behavior is a product of learning. Maintaining that behavior is altered through active participation in learning experiences, Wolpe (1958) stated that eliminating one's maladaptive behaviors and learning more effective behavior patterns could change present behavior. Wolpe (1958) believed that behavior was the product of learning and that we are simultaneously the end result of and the creator of our environment. Behaviorism was focused on taking action toward concrete changes in the client's life. Specifically, it was focused on changing certain behaviors or patterns in an individual's life to achieve positive results in the present moment.

Adler (1937) stated that one was influenced more by social factors than biological factors. Adlerian theory maintained that individuals create their own reality and are not trapped or limited by past experiences. Adler (1958) maintained that behavior was purposeful and was directed by a person's individual goals. This theory was one of the foundations of the growth model of psychiatric rehabilitation that stresses one's positive capacities to live fully in society. This form of therapy was characterized by working toward unity within the personality, understanding one's world from a subjective vantage point, and stressing life goals that provide direction to behaviors. Adlerian theory (1964b) asserted that social interests, a sense of belonging, and having a significant place in society are what motivated an individual. Self-direction, as well as social goals, were viewed as central to development and progress in

therapy. These objectives included promoting social interests, assisting one to overcome feelings of discouragement, fostering motivation, and instituting a sense of equality with others. It is believed that the values of socialization and community inclusion that Adler espoused in his therapy contributed to the development of the first clubhouse, Fountain House, founded in the 1950's in New York City (Beard, Propst & Malamud, 1982). Some of the more notable limitations to Adlerian therapy are weaknesses in terms of empirical validity, level of precision, and capacity to verify outcomes. As a result of this, little work has been done to try to scientifically test the efficacy of his theories.

Albert Bandura (1977) believes that a person's development is influenced by a dynamic reciprocal interaction between the environment, behavior, and one's psychological processes. He identified these psychological processes as the ability of individuals to maintain images in their minds and to use language. A basic tenet of Bandura's theory is that individuals are capable of self-directed behavior change, which is a core belief of psychiatric rehabilitation. With this concept, he deviated even further from traditional behaviorists and became a cognitivist.

Bandura (1977) formulated a social learning model that defined the five learning steps an individual goes through when attempting to learn a new skill. The first of Bandura's (1977) five steps is that the individual is taught the skill as a didactic process. The next is modeling, in which the individual watches the instructor perform the skill. The third step is role play where the individual role-plays or acts out the situations and skills in question. The fourth step is behavioral rehearsal in which the individual carries out the skill. The final step is a realistic work-practice, in which the individual practices

doing the skill in the real situation. Each skill progressively builds on the previously acquired skill so that the skills or behaviors are gradually learned.

Bandura (1977) demonstrated that one can learn by observing and imitating others. Bandura's social learning paradigm greatly influenced the development of psychiatric rehabilitation because it was the foundation for the skills development technology called "direct skills teaching" (Pratt et al., 1999). In fact, two very popular teaching strategies used in psychiatric rehabilitation today, skills training and direct skills teaching, are based upon Bandura's social learning theory. The importance of the cognitive behaviorist approach has been extremely significant to the development of psychiatric rehabilitation because it has also extended the range of individuals with whom intervention is possible. Behavioral techniques have demonstrated efficacy in treating clients with anxiety, phobias, relationship issues, adult psychotic behaviors, and childhood and adolescent behavioral challenges. Behavioral therapy gives clients practical strategies for change in their lives. As a result of the action-orientation of behavioral therapy, therapists actively assist clients in changing their behavior, instead of merely talking about their problems or gaining further insight into the problem. It is easier to measure effectiveness of the therapy in terms of assessment and quantifiable outcomes for research purposes. Behaviorism lends itself much more easily to empirical research and therefore is continually altering and improving on strategies for treatment based on evolving evidence acquired through research.

A criticism of behavioral therapy is that it does not adequately attempt to elicit the client's feelings or take into consideration the individual's past experiences. This therapy does not try to deal with the client's inner emotions nor does it give enough

attention to significant events in the individual's life. Therefore, the danger is that emphasis would be placed on treating and solving the problem and not on understanding the client's true needs. In contrast, experiential and client-centered therapies maintain that the client must feel fully heard and validated before any real progress on the issue can occur. It has also been noted that these behavioral therapies are too short-term to make a substantial and lasting impact on the individual's long-term well-being.

Contextual Theory

The fourth major category relevant to psychiatric rehabilitation is the most diverse because it contains those theorists who take into consideration the individual's unique context when evaluating his or her personal, educational, vocational, and rehabilitative goals. This unique combination of theories accurately illustrates the appropriate level of challenge and support necessary to help individuals with psychiatric disabilities identify their existing competencies and magnify their inner strengths in order to become a valued member of their chosen communities (Anthony et al., 2001 & Bisset, 2000). The five major theorists that will be addressed are Beatrice Wright, Franklin Shontz, Robert Carkhuff, Charles Truax, and William Anthony. Beatrice Wright developed the most complete integrative theory on reactions to physical disability. Wright was one of the founders of psychiatric rehabilitation and is best known for adapting psychosocial theory to physical disability. Wright espouses concepts such as treatment involving the whole person, and each person having a valued

role and membership in society. Wright acknowledges that rehabilitation is a continuous process that is always evolving.

In one of the earliest efforts to analyze psychosocial adjustment to disability, Dembo, Leviton, and Wright (1956) equated successful adjustment with a "coping" framework. The coping framework was predicated upon the following characteristics: (1) emphasizing the abilities, not the limitations of the person, which is very similar to the strength-based model of psychiatric rehabilitation, (2) taking responsibility and control for one's own life, which is the equivalent of person-centered planning in psychiatric rehabilitation, (3) recognizing personal accomplishments, which is the equivalent of positive reinforcement in psychiatric rehabilitation, (4) successfully managing negative life experiences, which is similar to perspective taking in psychiatric rehabilitation, (5) reducing limitations through changes in the physical and social environments, which signals the use of reasonable accommodations in both employment and educational settings in psychiatric rehabilitation, and (6) participating in and enjoying valued activities, which is helping individuals build social supports and integrating into the desired settings of their choosing in psychiatric rehabilitation.

Through her work, Wright (1983) encouraged individuals to shift their values in order to better cope with the realities of their disability. Coming to terms with the disability or accepting it as part of, but not as the defining characteristic of the individual, is the challenge. According to Wright (1983), this adjustment is the ability to maintain the perspective that the amount of loss created by the disability does not overshadow the positive attributes and strengths of the whole person. Many of Wright's

theoretical frameworks and value adjustment theories were the foundation of psychiatric rehabilitation and are still being actively implemented today.

Franklin Shontz (1978), a contemporary of Wright, questioned the concept of motivation. He determined that clients are not actually unmotivated, which is defined as a lack of willingness or energy (either emotional, physical or both) to maximize opportunities. Rather, he believed that clients are blocked or misdirected in the pursuit of their goals. This is the foundation for the term "readiness" that is used in psychiatric rehabilitation. The term readiness means that clients must have the proper information and skills in order to take advantage of the situation of their choosing.

Like Rank, May, Rogers, and Wright, Shontz (1978) also pointed out that the relationship between the staff and the client has a dramatic effect on the outcomes of the rehabilitation. Shontz (1975) perceived psychological adjustment as a final stage in his theoretical framework to explain an individual's response to disability. Shontz (1975) viewed adaptation as a dynamic satisfying integration of both subjective experience and external environment. The evolving process of adaptation requires the individual to be aware of and responsive to environmental cues. This can be demonstrated by evaluating one's mental state, one's understanding of available resources, and one's interpersonal skills. A successful adjustment implies a change in the individual's experience of oneself and a reintegration of one's relationship with the environment, which in turn leads to a renewed sense of worth. The better the match between the inner thoughts of the individual and the external reality, the better the level of adjustment.

Shontz (1965) put forth the statement that the challenge facing health professionals in the future will be to restore human integrity by acknowledging the mental processes of individuals and not to simply succumb to a simple mechanistic or purely behavioral way of assessing human behavior. Shontz maintained that the results of an individual's success are not limited by the individual's personal traits or disabilities but by the ability to adapt to the environment. This is a central tenet of psychiatric rehabilitation. The individual has unlimited potential if given the appropriate supports and environmental match to develop his or her existing competencies. Finally, Shontz (1965) had a critical role in the development of psychiatric rehabilitation because he believed in treating the whole person and not separating out the person's body and mind into separate and distinct categories.

Like Shontz, Robert Carkhuff combines cognitive and behavioral therapies. Collaborating with Carl Rogers, Carkhuff (1972) further developed and fully operationalized many of Rogers' insights. In particular, Carkhuff uses reflective skills in the therapeutic relationship. Carkhuff (1972) believes in "action orientation" in which the client decides on a plan of action and then follows through on the decided behaviors. Upholding that action orientation is crucial to counseling effectiveness, Carkhuff (1972) states that defining goals and taking action steps toward them is as important as gaining greater insight into one's situation; whereas Rogers (1959) believed that it was the actual therapeutic exploration between the client and therapist that greater understanding and progress was made. In contrast, Carkhuff (1972) also believes that this newly developed understanding is important, but only if it is used to facilitate action. He wanted his clients not only to reflect upon their feelings, but to use

the insights they achieved to take action toward improvements in their lives. Carkhuff (1972) was categorized as a behaviorist because of his belief that the therapist should facilitate the client's progress toward effective action (Wolpe, 1966). Carkhuff agreed with Wolpe (1966) that behavior was a product of learning. Carkhuff integrated the humanistic theories of Rogers (1959) with the behavioral theories of Wolpe (1966), and established himself as a significant figure in psychiatric rehabilitation (Anthony et al., 2002).

By incorporating the behaviorist views into a humanistic paradigm, Carkhuff (1972) believes that a counselor could help induce positive client change. At the same time, however, he feels that a counselor can also facilitate change that could have negative consequences for the client. He believes that the effective counselor should have interpersonal skills that are motivating, therapeutic, and/or change-inducing. He maintains that empathy, non-possessive warmth, and genuineness elicits a variety of socially and individually valued positive behavioral changes. Carkhuff (1972) also held the belief that an accurate and sensitive awareness of the other person's feelings, aspirations, values, beliefs, and perceptions is an essential skill of a good counselor. He believed greatly in the importance of a genuine openness on the part of the counselor. Carkhuff states that the client should be actively involved in the change process at all times. Carkhuff (1986) sought to discern and evaluate how a therapist can connect in empowering ways with another person. Carkhuff's goal was to reduce the helping process to comprehensible steps that can be readily understood and applied. Carkhuff (1969) underscores that the most effective and direct form of training is to instruct the client directly in the exact conditions or environment necessary to improve functioning.

Truax (1967), who worked closely with Carkhuff, also believed in the careful and purposeful integration of the cognitive and behavioral schools of thought. Truax believed that well-developed communication skills are essential to effective counseling and in the selection and training of helping professionals. Like Carkhuff, Truax underscored the importance of the helping relationship. He affirmed that the therapist is the catalyst for action and a role model for the client. Building on Carkhuff's ideas of the direct training of clients, Truax elucidated the concept of "teaching as treatment," an in-depth theory of rehabilitation (Carkhuff & Berenson, 1981). Truax (1967) and Carkhuff (1967) conducted a direct form of "teaching as treatment" in which the client is personally trained by the therapist in the skills in which he or she needs to function effectively. The goal of such treatment, Carkhuff (1969) explained, is to train the client to develop his or her own training program to acquire the necessary skills needed to heal. It is hoped that this training will develop interpersonal skills among other skills necessary to function in a desired environment, to assist the client to develop and determine effective actions, and for the intervention to be replicated by other programs to achieve the desired results (Carkhuff, 1969). This form of teaching as treatment later evolved into the basis of skills training. Rehabilitation technology utilized modeling of the specific action for the client to learn and then replicate as needed in the chosen environment. Both Truax and Carkhuff were substantial influences on the development of skills training, which led to the development of rehabilitation technology.

William Anthony (1979a), who was greatly influenced by Beatrice Wright and was a student and colleague of Carkhuff, created the psychiatric rehabilitation approach. Anthony's approach is considered by most to be a model, yet he asserts his view of

rehabilitation as an approach. Anthony emphasizes interventions in order to improve functioning, to compensate for the psychiatric disability, and to better adapt the environment to meet the specific needs of the individual. In this approach, Anthony (1979a) seeks to create a person-centered theory that incorporates all of the influential factors in individuals' lives so that they may have the opportunity to experience fuller lives through rehabilitation. Anthony (1979a) strives to match the rehabilitation process to an understanding of an individual's strengths and the demands of the environment. Influenced by the physical rehabilitation model of Rusk and Taylor (1949), Anthony uses this approach to help educate the mental health field. He compares the rights and rehabilitation strategies of individuals with physical disabilities to those with psychiatric disabilities. Anthony's (1982) contribution to the field of psychiatric rehabilitation is significant because he believes that individuals with severe psychiatric disabilities can improve their level of functioning and quality of life through rehabilitation. This approach acknowledges the etiology of the psychiatric disorder, the past experiences of the client, and the limitations that are characterized by the diagnosis. Yet Anthony's approach takes these issues into consideration only as they are relevant to the clients' understanding of their current situation and the bearing they have on the clients' future choices and goals.

Values of Psychiatric Rehabilitation

The field of psychiatric rehabilitation is organized around the values and needs of the individual in the moment. It is less theoretically based, but far more values-driven and person-centered (Anthony et al., 2002). The most important value is treating

a person as an individual, not as the illness he or she experiences. The emphasis is on maximizing strengths rather than on "fixing" the "problem." According to this value, rehabilitation focuses on a person's strengths, not on the limitations of the psychiatric disability. Another important value is the focus on an individual's role performance as a desired outcome. This approach differentiates psychiatric rehabilitation from other significant mental health services whose goals may be to reduce symptoms or to improve insight (Anthony et al., 2002). One of the main objectives of psychiatric rehabilitation is to improve functioning, which means to develop one's performance of everyday activities. The goal is not to make everyone the same, but to enable individuals to develop their own capacities and skills. Providing support with environmental specificity is crucial because individuals behave differently in varying environments. Psychiatric rehabilitation emphasizes assessing individuals in specific relationship to the demands of their chosen environments (Anthony et al., 2002). Helping individuals to improve their role capacity in a particular living, learning, working, and/or social environment is central to the mission of psychiatric rehabilitation. This outcome is achieved through behavioral modification interventions that use modeling and activity to guide the individual's development, rather than verbal therapy (Anthony et al., 2002). This mission stresses the maximizing of growth potential of each individual regardless of present level of capability (Anthony et al., 2002). In this sense, psychiatric rehabilitation is centered on an observable outcome, rather than on the specified service goal. Success is measured in terms of the person's ability to respond to environmental demands, while satisfaction is based upon the person's own interpretation of the experience.

Psychiatric rehabilitation is often criticized for not taking into consideration the therapeutic value of past dreams, the individual's unconscious, early childhood experiences, trauma, and transference. Anthony does not discard the individual's etiology, past experiences, or their unconscious thoughts, but instead believes that individuals can be empowered by the techniques and strategies of psychiatric rehabilitation to reach their self-articulated goals. Anthony acknowledges that an individual may or may not choose to work on past issues in other forms of therapy and believes strongly in the value of many forms of treatment, including antipsychotic medications, to address the etiology of psychiatric disability. Yet, he feels that psychiatric rehabilitation's power is in the focus on the potential one may achieve through its recovery process (Anthony et al., 2002). Since this paper has evaluated the four main psychological areas that have influenced psychiatric rehabilitation, next this paper will examine the three main components of psychiatric rehabilitation: recovery, supported employment, and supported education.

Recovery

The preceding four theoretical frameworks are the foundation which made it possible for psychiatric rehabilitation to go to the next level and create the three critical components central to the holistic development and well-being of individuals experiencing severe psychiatric disabilities, which are as follows: recovery, supported employment and supported education. These next three sections will explore these concepts and evaluate the empirical evidence that examines the study's effectiveness.

Table 1. Theoretical Underpinnings of Psychiatric Rehabilitation

I. Analytical Approach and Insight Theories
1) Freud - development must take into account individual's past. 2) Rank - emphasized importance of current experiences of the client. 3) Erickson - believed that learning is progressive over the lifespan of the individual and that they are not limited by childhood traumas or challenges.
II. Experimental and Relationship-Oriented Theories
1) May - emphasized freedom of choice, personal responsibility, and self-determination. He characterized man's existence as evolving and never stagnant. He adopted the humanistic approach and stressed individual respect. 2) Rogers - emphasized strong communication between client and therapist. He stressed the importance of client's view of himself and that he should shape his future by making pro-active choices to reach his expressed goals. 3) Raskin - stressed the acceptance of client's expressed feelings. He wanted a greater concentration on the client's internal frame of reference and appreciation of the self-concept.
III. Action Oriented Theories - Cognitive and Behavioral
1) Wolpe - believed that behavior was a product of learning. He stated that the individual can learn more effective behavior patterns by taking more concrete actions in his or her life. 2) Adler - stated that one was influenced more by social factors that biological factors. He believed that an individual created their own reality and could gain more control over their lives despite past experiences. 3) Bandura - formulated a social learning model consisting of five steps an individual goes through when trying to learn a new skill. He believed one could learn by observing and imitating others through self-efficacy.
IV Contextual Theory
1) Wright - advocated psychosocial theory and treatment of the whole person. She maintained that the individual has a valued role and stated that rehabilitation is a continuous process. 2) Shontz - determined that clients are not naturally unmotivated but are blocked or misdirected in pursuit of their goals and that individuals have the capacity to improve their readiness if given access to the appropriate resources and supports. 3) Carkhuff - believes in "action orientation" in which the client decides on an action plan and follows through on decided behaviors. He emphasizes that defining goals and taking action steps leads to an individual's greater growth and self-improvement. 4) Truax - stated the importance of well-developed communication in counseling. He believed that the therapist catalyzes action and serves as a role model. He underscores the importance of the helping relationship and "teaching as treatment" where the client is trained in skills to function effectively. 5) Anthony - asserts his view of rehabilitation as an approach. He stresses intervention in the form of resources, supports, and adaptation of the environment to improve functioning and quality of life of an individual.

Just as rehabilitation was seen as a possibility a decade ago for individuals experiencing psychiatric disabilities, recovery and reintegration into the community is now a feasible reality. Recovery was introduced as a vision to the field of psychiatric rehabilitation in the 1990's. Although a new paradigm to many, consumers and some researchers such as Harding and Anthony have been writing about it and researching it

for decades (Brooks, Ashikaga, Strauss & Breier, 1987a; 1987b). Recovery is finally accepted as a possible outcome measure in psychiatric rehabilitation worldwide (Anthony et al., 2002). Recovery does not mean curing severe psychiatric disabilities (Anthony et al., 2002). Instead, it emphasizes learning to work within the limits of the disability. Anthony defines recovery as the process of empowering individuals with hope and self-esteem to "recover" valued social roles and find new meaning and purpose in their lives (Anthony et al., 2002). Deegan (1997) stresses that the journey of recovery for individuals experiencing severe psychiatric disabilities is very personal and unique. Deegan (1988) defines recovery as an internal process of change whereby individuals "experience themselves as recovering a new sense of self and purpose within and beyond the disability" (p. 22). Harrison (1984) states the concept of recovery from physical illness and disability does not always mean the suffering has disappeared, all the symptoms are removed, and/or the functioning has been completely restored.

Anthony et al. (2002) states that psychiatric rehabilitation has three goals: recovery, community integration, and enhanced quality of life. In the field of psychiatric rehabilitation, the prevailing belief before 1970 was that individuals with severe psychiatric disabilities would never be able to improve their psychiatric condition regardless of the level of support or treatment that was available to them. Until the late 1970s and early 1980s, the conventional wisdom about individuals with severe psychiatric disabilities was that the symptoms were persistent and degenerative and there was no prescribed course of action toward improvement or recovery. Yet research has demonstrated that individuals with severe psychiatric disabilities can

improve and do recover (Desisto, Harding, McCormack, Ashikaga & Brooks, 1995). Evidence documents that individuals with severe psychiatric disabilities can and do go on to take on productive and valued roles in the workplace and in the community (Harding et al., 1987). Harding (1994) states:

> ...results from five recent investigations studying the long term "outcome" of schizophrenia (in Switzerland, Germany, and the United States) indicate that no matter how chronic the cohorts were, approximately 25% of the subjects achieved recovery at follow-up, with an additional 25-40% improved, with achievement of wide heterogeneity as the rule rather than the exception. (Harding, 1994, p. 15)

In fact, these studies and other studies of shorter duration (Bland & Orn, 1980; Gardos, Cole & LaBrie 1982; Hawk, Carpenter & Strauss, 1975; Strauss & Carpenter, 1974; Strauss, Kokes, Ritzer, Harder & VanOrd 1978; WHO, 1979) agree with Harding and Strauss's conclusion that the course of severe psychiatric disabilities "is non-linear in its patterns, moving toward significant improvement over time and helped by an active, developing person in interaction with his or her environment" (Harding & Strauss, 1985, p. 339). Harding (1994) and her associates have reviewed a number of long term research studies, including her own, with Brooks, Ashikaga, Strauss and Breier (1987a; 1987b) and found that the expected deteriorating course was not the usual circumstance over time. In fact, it happened only 10% of the time. Harding, Zubin and Strauss (1987) concluded that the possible causes of chronicity may not be linked directly with the diagnosis but more with the environmental and social factors that the individual encounters.

Outcome-Oriented Recovery Research

Unlike Anthony et al. (2002) and Deegan (1988), who view recovery along a broad continuum within a wider array of possible and continual processes, Harding's research definition of recovery is outcome-oriented rather than process-oriented. According to Harding (1994), recovery is defined as:

> ...no sign or symptoms of psychiatric disorder, no psychotropic medications, working or retired appropriately after a work history, (especially important because the average age at follow-up was 61 ranging up to 86 years of age), maintaining mutually satisfying interdependent relationships, the absence of behavioral or contextual indicators that they were formal mental patients and integration into the community as full-fledged citizens. (Harding, p. 155)

Harding agrees with Vaillant (1975) who states "diagnosis and prognosis should be treated as two different dimensions of psychosis." Chiftick, Brooks, Irons, and Deane (1961) studied 269 Vermont State hospital patients with severe and persistent psychiatric disorders (especially with schizophrenia) who were rehabilitated in a model demonstration program, and then released into the community in the mid-1950s. At the time of entry into this project in the 1950's, these subjects had an average of six years of continuous psychiatric hospitalization and sixteen years of disability. This was the most chronic cohort ever studied. A five to ten year follow-up study in the 1960's revealed that two thirds of the subjects were living in the community and their well-being was maintained by considerable investment of time, money, and effort (Deane & Brooks, 1967).

The characteristics of the rehabilitation program in the Vermont study were as follows: the psychiatric clinics were organized like community mental heath centers; the continuity of care in the program took place both in the hospital and in the

community; there were four rehabilitation wards at the hospital and two rehabilitation workers assigned to the hospital; and integrated modalities such as social psychiatry, medical, and vocational rehabilitation were provided. New community, work options, and case management were also part of the program. Linking study participants to natural supports in the community through vocational rehabilitation workers was part of the rehabilitation as well. Twenty to twenty-five years after their entry into this program, 97% of the group were found and assessed. Raters, who were blind to record information, did the two field interviews. The first interview provided a multivariate cross-sectional assessment of outcome (Harding et al., 1987a; 1987b). The second interview included a Meryerian/Leighton Life chart (Leighton & Leighton, 1949; Meyer, 1919) and contributed a longitudinal documentation of patterns, shifts, and trends in the course of life for members of the cohort (Harding et al., 1987a; 1987b). Of particular significance was that the record raters were blind to the outcome and field data, and the battery of tests were subjected to inter-rater trials and inter-item concordance testing (Harding et al., 1987a; 1987b). In order to make the subjects comparable to today's patients, the DSM-III criteria (American Psychiatric Association, 1980) were matched to the index status with records that were stripped of all previous diagnostic assignments (Harding et al., 1987b). This study also used 15 standards and scales which was unique because, in the past, other studies used clinical interviews.

Harding (1987) documented in her landmark study that an analysis of the long-term outcomes for individuals meeting the DSM-III criteria for schizophrenia revealed a wide heterogeneity of outcomes. Approximately one-half to two-thirds of the sample had achieved considerable improvement or recovered, in contrast to statements in the

DSM III that predict a poor outcome for schizophrenic patients. "For one-half to two-thirds of the group, the course was neither downward or marginal" (Harding et al., 1987a, p. 362). Harding (1994) continues

> The finding was remarkable because these patients represented those in the 'bottom third' of the schizophrenia spectrum and the back wards in the hospital. Most people resided in the community, were able to care for themselves, had become actively involved with family and friends, and made productive contributions to their families and communities with little or no residual display of symptomatology. (Harding et al., 1987a, p. 365)

These findings were similar to the full cohort, which included patients with a wide variety of DSM-III diagnoses (Harding et al., 1987a). It is important to note that the more stringent criteria applied to the DSM-III were not associated with universally poor outcomes which were projected (APA, 1980).

Harding's follow-up work in the same study (DeSisto, Harding et al., 1995a; 1995b) involved a comparison of the long-term outcome of people with psychiatric disabilities in two different states. The state of Vermont created a ten-year pioneering and comprehensive psychosocial and vocational rehabilitation program. Before the study, it was difficult to ascertain if the program had an impact on the outcome findings because all of the patients who were in the back wards of the only Vermont state hospital were selected, with the exception of those on legal mandates, those with developmental disabilities, or those over 62 years of age. Fortunately, in terms of an appropriate comparison group, Augusta State Hospital in Maine was another New England hospital with a similar catchment area and one hospital without a rehabilitation program that provided a matched comparison sample. The Maine cohort was then put through the exact same protocol, the same diagnostic criteria, and instrument batteries

with intra-project and inter-project reliabilities established, as well as blindness in the data collection. Ninety-four percent of the individuals with psychiatric disabilities from Maine were assessed at an average of 36 years after the onset of the psychiatric disability. DeSisto, Harding, Ashikaga, McCormick and Brooks (1995) state that this was the first time in longitudinal research that two studies that included long durations matched samples, protocols, diagnostic criteria, and historical periods. This information was verified using health and census data.

Annual comparisons revealed that the Vermont rehabilitation program had a significant impact on the course of the psychiatric disability for Vermont subjects compared to those of Maine subjects who did not receive any form of rehabilitation (Harding, 1994). Important aspects of the Vermont rehabilitation program gave Vermont patients an earlier opportunity to adapt to life in the community. This opportunity, when combined with an array of residential, work, and social opportunities, resulted in a more diverse and favorable course compared to the Maine group area domains studied. DeSisto et al (1995) concluded "rehabilitation and the opportunity to be out of the hospital joined with biological correction mechanisms potentiate a return to the highest level of function possible for each person" (p. 156).

Role of Family and Professional Support in Recovery

Support from peers, friends, family, and mental health professionals are essential to recovery from psychiatric disabilities (Anthony et al., 2002). Family members often provide an individual with a psychiatric disability some level of hope (Deegan, 1998). Liberman, Kopelowicz, Ventura and Gutkind (2002) define family

support as involving acceptance, warmth, understanding, a caring approach toward progress, and positive encouragement. Research has demonstrated that involving the families in the process of recovery plays an instrumental role in an individual's progress. The role of the family in recovery from severe psychiatric disability has become critical as a result of deinstitutionalization and community reintegration (Pratt, Gill, Barrett & Roberts, 1999). With long-term hospitalizations becoming a concept of the past, the family has become the locus of care for the individual (Hatfield, 1987b). Family members are discovering that they can become valued participants in the recovery process (Manion, 1996). Family interventions are usually focused on education, support, problem solving, and crisis intervention.

While professional mental health support is important, an increased level of diverse support reduces an individual's sense of isolation and also increases one's own sense of hope and empowerment (Deegan, 1996). It is understood that hope is integral to the process of recovery from psychiatric disabilities. Hope is a feeling or desire accompanied by a confident yearning (Deegan, 1996). It is the small hint or idea that an individual can attain improved health and lead a satisfying life. Early on in the recovery process, it is critical for a family member, friend or peer to hold hope for the individual when he or she has no hope to draw upon (Deegan, 1996). Yet for the recovery process to be genuine, the individuals must cultivate their own sense of hope. Lehman and Steinwachs (1998) state that relapse or re-hospitalization of individuals with psychiatric disabilities can be significantly reduced by family intervention in conjunction with psychotropic medications. This progression toward recovery is dramatically more significant than when medication is used alone.

Family Education Models

One of the fundamental principles of psychiatric rehabilitation is creating a partnership with the individuals receiving the services and their family members (IAPSRS, 1996). Cook and Hoffschmidt (1993) document the importance of family involvement in treatment, rehabilitation, and full participation in overall support of the individual with a psychiatric disability. Lehman and Steinwach's (1998) research confirms that family interventions have been one of the most effective approaches to helping individuals with severe psychiatric disabilities. Psychoeducation of families and individuals with psychiatric disabilities is an essential family intervention that helps ensure that both parties have accurate and helpful information about the effects, treatment, and rehabilitation of the psychiatric disability so that they can develop reasonable expectations and take effective actions toward recovery (Hatfield, 1990). Community-based support systems, integrated settings and natural supports are all essential elements in psychiatric rehabilitation. The mission of such comprehensive services is conducive to the development of effective partnerships with families (Pratt et al., 1999). The research by Cook and Hoffschmidt (1993) supports the mission that since individuals with psychiatric disabilities may potentially need some level of support throughout their lifetime, family members act as a practical and productive choice to engage in the long-term rehabilitation process.

Anderson (1986) proposes guidelines for psychoeducation based upon research that could be used toward goals in trying to work with families. Such guidelines include: (1) striving to create a mutually respectful working alliance with the family; (2) trying to be proactive in understanding family dynamics that may lead to a greater level

of discomfort for the individual or the family; (3) assessing the family's resources and the history of their coping strategies; (4) building interventions upon families strengths; and (5) creating goals that are both mutually beneficial, measurable, and attainable.

Hogarty, Anderson, Konrblith, Greenwald, Javana and Moadonaia (1986; 1991) developed a family focused learning model by creating situations in which families could empower themselves through education, learning useful skills, and adopting helpful attitudes. It included creating a strategic partnership with the family, providing explicit information and implementation strategies, and developing a support network at a one-day skills building seminar. One of the most significant research findings of Hogarty et al. (1996; 1991) was that after two years, only 25% to 29% of the individuals who received the family treatment relapsed, compared to relapse rates in excess of 62% for individuals who received social skills training or day treatment alone. Another critical component of psychiatric rehabilitation is supported employment, which will be discussed in the next section.

Supported Employment

Supported employment is an important part of the recovery process. Meaningful work is described as one of the functional indicators of healing and growth beyond the disability, and is seen as essential in recovering a personal sense of self-worth. (Bond, 1996; Deegan, 1997; Spaniol, Gagne & Koehler, 1999; Spaniol, Koehler & Hutchinson, 1994). Meaningful work is defined as tasks that an individual is both successful at and finds satisfying. Meaningful employment is an essential component of the recovery process (Leete, 1992). Despite these findings, there is very little in-depth qualitative

research documenting what is considered meaningful work for individuals experiencing severe psychiatric disabilities.

Anthony, Howell, and Danley (1984) explain employment support as an "individualized instruction and support program, which assists individuals with psychiatric disabilities to obtain job goals. The goal of these services is to help participants choose, get, and keep a job in which they feel satisfied and successful" (p. 76). Similarly, psychiatric vocational rehabilitation is the process of helping people with severe psychiatric disabilities to choose, get, and keep the job or educational opportunities they prefer (Anthony, Cohen, Farkas & Gagne 2000; Sullivan, Nicolellis, Danley & MacDonald-Wilson, 1994).

The mission of psychiatric vocational rehabilitation is to assist individuals with severe psychiatric disabilities to be satisfied and successful in their preferred environment with the right skills, resources, qualifications, and supports (Anthony et al., 2000). Anthony and Blanch (1987) recommend that individuals experiencing severe psychiatric disabilities should have the opportunity to increase their level of education, learn marketable job skills, and enhance their coping skills. This supportive educational treatment model should be, at least in part, similar to a supported employment model which includes the infusion of pre-employment supports such as job readiness and job search training, as well as life skills training and post-placement services (Anthony & Blanch, 1987). Anthony, Howell, and Danley (1984) first described the "Choose-Get-Keep" approach to vocational services for people with psychiatric disabilities. Danley and Anthony (1987) later applied this concept to supported employment services and

the Center for Psychiatric Rehabilitation at Boston University continues to use and research the "Choose-Get-Keep" approach to supported employment.

Essentially, the three sets of program activities - choosing, getting, and keeping - parallel the supported employment components described as pre-employment, placement, and training/follow-up (Moon, Goodall, Barcus & Brooke, 1986). Inherent in this approach is the principle of mutual responsibility for outcome. The student and the supported employment agency negotiate varying levels of participant/practitioner responsibility for selecting, securing, and sustaining employment. This negotiation is based upon an exploration of the student's competencies, resources, and preferences, as well as the characteristics of the natural work environment. As discussed by Nisbet and Hagner (1988), the concept of support is perceived broadly, and includes support provided by job coaches, co-workers, supervisors, attendants, families or case managers. Similar to the place-train approach, work adjustment and technical skills are developed or refined after the person is placed.

The "Choose-Get-Keep" supported employment model emphasizes personal choice in the identification of a career goal that is consistent with the person's interests, skills, abilities, and aspirations (Danley & Anthony, 1987). This process of active and participatory career assessment may help to counter the historic precedent that individuals with severe psychiatric disabilities are passive service recipients who do not have a voice or choice in their own vocational recovery (Danley & Anthony, 1987). The right training and support can help to empower individuals with severe psychiatric disabilities to develop their own strengths and self-sufficiency. One of the goals of recovery is self-sufficiency and decreased reliance on subsidy programs.

With the introduction of a new generation of rehabilitation strategies and psychotropic medications, many individuals with severe psychiatric disabilities are recovering and seeking to participate in the workforce. Functional skills deficits, vocational and educational gaps, and societal stigma still constitute significant barriers to successful reintegration and well-being (Anthony et al., 2002). Rates of employment among individuals with severe psychiatric disabilities are extremely low, with most studies reporting rates of less than 15% (Bond et al., 1999). Over the past five years, a variety of vocational rehabilitation approaches (e.g., preparation for employment through skills training, pre-vocational work crews, sheltered employment, and temporary jobs) have all been developed to improve vocational outcomes for individuals with severe psychiatric disabilities (Bond, 1992). The underlying assumption is that work is beneficial and therapeutic, that it increases self-esteem, increases control of psychiatric symptoms, and improves individual quality of life (Black, 1988). Since the goal of increasing employment rates using traditional vocational approaches has been extremely challenging the supported employment approach has been used (Bond, 1992; Bond, Drake, Becker & Mueser, 1999). This approach utilized "rapid, individualized search for community jobs tailored to each client's strengths and preferences, ongoing support on a time-limited basis, and close coordination between vocational and mental health treatment staff" (Drake & Becker, 1996, p. 33). As a result, supported employment has produced higher employment rates than traditional vocational approaches (Bond et al., 1999).

Supported employment (SE) is intended for individuals experiencing severe psychiatric disabilities and is defined as paid work that takes place in regular work

settings with provisions for ongoing support services (Anthony & Blanch, 1987; Bond, et al., 1999). The supported employment approach assumes that everyone, regardless of the level at which one is experiencing severe psychiatric disabilities, is able to do meaningful and productive work in traditional work settings if that is what one chooses to do and is given access to appropriate levels of supports (Anthony & Blanch, 1987). The SE model explains that unfavorable outcomes are not a result of challenges associated with the disability, but to inappropriate job matches that do not meet the interests, skills, or abilities of the individual. In support of Anthony & Blanch's (1987) findings, Bond et al. (1999) reviewed the effectiveness of psychiatric rehabilitation approaches for employment of individuals with severe psychiatric disabilities. In Bond's study, the level of effectiveness of SE was consistently favorable (Bond et al., 1999).

Research on Supported Employment

Danley (1993) conducted a supported employment project with 22 participants with serious long-term psychiatric disabilities between the ages of 18 and 55 who were Massachusetts residents. The program took place at Boston University's Center for Psychiatric Rehabilitation, and the model used in the study was the "Choose-Get-Keep" model of supported employment. This version of the model was adapted from the other supported employment models including the psychiatric vocational rehabilitation model (Danley, 1993). In this version, time is allotted during the program in the pre-employment process for clarification and definition of participants' values. These participant-generated value definitions became the primary source of information for

both the participants and staff in the development of an employment goal and possible employment options (Danley, 1993). Roles and responsibilities related to placement or the "getting" of a job was negotiated on an individual basis between the participant and staff. Disclosure, which is the decision to inform or not to inform an employer about one's psychiatric disability, was left up to the participant (Danley, 1993). Participants took on the primary responsibility for all job seeking and searching tasks. Sometimes the staff took on a more active role in job development when the participant expressed the need for employment support (Danley, 1993). Both staff and participants decided that job stabilizers and job integration supports were better accomplished through off-site services. Job coaches were believed to increase stigma by working with the individual with psychiatric disabilities. For example, having a job coach on site may call attention to an already nervous new employee and give the appearance that the participant is less than because he/she needs assistance on the job. This could make it even more difficult to fit in or become comfortable on a job if the employee is already viewed as different or in need of special assistance. The presence of a job coach on site could therefore hinder the process of successful integration and becoming stable at the workplace (Danley, 1993).

The results of this study indicated that six individuals were employed and sixteen were unemployed at the onset of the project. Five of the six who were employed at the start of the program remained employed (Danley, 1993). Eight out of the sixteen who were unemployed became employed; three were involved in volunteer positions. Two people became interested in education programs and were not interested in pursuing employment at that time. The remaining four individuals were not engaged

in educational or employment pursuits (Danley, 1993). Seventy-three percent of project participants achieved paid employment at some point during the project. At the end of the program, 59% received paid employment. Of these 59%, participants reported a moderate level of job satisfaction and a high level of satisfaction with project staff. The mean hourly wage for the participants in the study was $8.28 and the mode was $6.00. The range for the hourly wage was between $4.33 and $16.28 (Danley, 1993).

The Impact of Disclosure on Supported Employment

Given that significant stigma remains around the issue of psychiatric disability, many individuals choose not to disclose, meaning not revealing one's disability to one's employer. It is still a very personal and complicated process (MacDonald-Wilson, 1997). Disclosure is an extremely significant topic in the area of supported employment because the choice to tell or not to tell an employer that one experiences a psychiatric disability can significantly impact one's career trajectory.

Ellison and Russinova (2002) conducted a national survey of 495 professionals and managers with psychiatric conditions to evaluate workplace disclosure among them. This non-representative targeted study, the first of its kind, had a preferential sampling strategy. The sample consisted of 495 managerial professionals who had recovered from or were currently experiencing psychiatric disabilities and maintaining a high level of employment. Eligibility criteria for the study included employment as a professional or manager for at least six months in the past five years and the presence of a serious mental illness.

There were two sub-samples in the study. The first included 350 individuals employed in health and social services, business, technical, educational settings, and traditional health services. The second sub-sample was comprised of individuals excluded from traditional mental health services. The demographics were largely female, middle-aged, and predominantly Caucasian. This well-educated group had middle incomes with 57% earning over $30,000 per year. Mood disorders were the predominant diagnosis, nearly 80%, with at least one prior psychiatric hospitalization. Most subjects took medications at the time of the study. The occupational data found that the majority, approximately 62%, were professionals or worked as senior technicians. The next largest proportion of participants, approximately 28%, worked as executives, managers, and administrative personnel. The findings revealed that of the 395 survey participants, 303, or 87%, reported having disclosed their psychiatric condition on the job. Of those 303, 101 participants (33%) of those who disclosed did so at the time of applying for the job; the remainder disclosed at later times. Most frequently, approximately 80% of the time, they disclosed to their supervisor. Therefore, Ellison and Russinova's (2002) research documented that severe psychiatric disabilities are not necessarily career-limiting disorders. Results indicated that 73% found employment in occupations that fulfilled their potential, ranging from semi-professionals to executives. Many formed meaningful, well-paying careers in which they thrived; and found that the work itself proved to be therapeutic (Ellison and Russinova, 2002).

The implications of this research are far-reaching, with significant practical consequences for the lives of the 5.5 million in the United States with severe psychiatric

disabilities nationally, with the unemployment rate for such individuals being 85% (Anthony & Blanch, 1987). The U.S. General Services Administration (1996) states that 70% of these individuals depend on federal subsidy programs such as Social Security Insurance (SSI) or Social Security Disability Income (SSDI), and few move into competitive employment. This excessive underemployment is an artifact of insufficient resources and programming designed to assist these individuals to become productive workers. Despite their level of experience, intellect, or dreams, individuals with severe psychiatric disabilities have been pushed toward low-wage or menial jobs. They often remain dependent on the government; and therefore live near, at, or below poverty level.

The Legislative Influence on the Delivery of Psychiatric Vocational Rehabilitation

To fully understand the process of recovery one must understand the societal, political, and legislative context that existed during the late 1990's. To appreciate the influence of the Americans with Disabilities Act (ADA), one must first understand the historical proceedings of the 1970's and the 1980's that marked the struggle of all individuals with disabilities toward the common goal of full participation in American society (Alexander, 2003). The need for all individuals, regardless of their disability, to participate fully in their community led to the passage of the Rehabilitation Act of 1973 and the Education for All Handicapped Children Act of 1974. The former, among other things, prohibited discrimination in local programs on the basis of disability. If a federally subsidized program chose to exclude an individual with a disability, funding was removed. Enforcement of this policy resulted in individuals with psychiatric

disabilities gaining access to health care programs, social services, housing, transportation, and other important services (Alexander, 2003). It also opened educational opportunities to individuals with disabilities on all levels. The reauthorization of the Rehabilitation Act of 1973 resulted in the Rehabilitation Amendments of 1992, legislation that "promotes consumer participation and empowerment and the opportunity to create services that meet an individual's educational and vocational needs" (Mowbray, Staunch Brown, Furlong-Norman & Sullivan-Soydan, 2002, p. 2).

The Individuals with Disabilities Educational Act of 1990 (IDEA) was created to improve educational interventions and outcomes for individuals with disabilities (Mowbray et al., 2002). The Americans with Disabilities Act of 1990 mandated equal access and accommodations for all individuals with disabilities to both public and private academic and employment settings (Brady, 2003). A "person with a disability" according to the ADA, "is anyone experiencing significant limitations in a major life activity-such as breathing, speaking, walking, seeing, etc." (Mowbray et al., 2002, p. 2). In order to ensure that individuals with psychiatric disabilities are given the same employment opportunities as other employees, sometimes special provisions must be made to help adjust the working environment to meet the needs of the individual. These provisions are known as reasonable accommodations.

Reasonable Accommodations

A reasonable accommodation is a modification or adjustment to an educational or work environment so the student or employee with a disability can perform the essential functions or requirements (MacDonald-Wilson, 1997). Reasonable accommodations are necessary in order to prevent discrimination against individuals with disabilities, and/or to prevent exclusion of individuals on the basis of the disability (Jarrow, 1992). The purpose of providing reasonable accommodations is not to give individuals with disabilities an unfair advantage, but to give them equal access to activities to which they would otherwise be denied (MacDonald-Wilson, 1997). The adjustments or accommodations might be in the form of equipment, schedule changes, and/or re-assignment of some duties.

Given that significant stigma remains around the issue of psychiatric disabilities, many individuals choose not to disclose. Disclosure is still a very personal and complicated process (MacDonald-Wilson, 1997). However, in order to receive a reasonable accommodation the individual must disclose. Under the ADA, a prospective employer may not legally inquire about the existence, nature, or extent of a disability. Furthermore, the person cannot be held liable for non-disclosure (MacDonald-Wilson, 1997). For research and specific examples of reasonable accommodations please see Appendix E.

The Americans with Disabilities Act dramatically influences how services are delivered to individuals with psychiatric disabilities. As a result of this legislation, individuals are often encouraged by service providers to disclose their psychiatric disability to receive protection provided by the law. Individuals with psychiatric

disabilities are now also extensively educated about their right to reasonable accommodations so that they can choose, get, and keep employment in an optimally functional environment. Unfortunately, the law has not improved vocational outcomes as significantly as the field of psychiatric rehabilitation has anticipated because it is difficult and time consuming to document and enforce when violations occur (Bond, Drake, Becker & Mueser, 1999).

Summary of Supported Employment

Supported employment provides greater access to the world of work for individuals with severe psychiatric disabilities. Providing information around the issues of disclosure gives individuals with psychiatric disabilities choices around who, what, when, how, and why to inform individuals in the workplace about their condition. It also allows them the option of being protected under the Americans with Disabilities Act (ADA). The ADA provides the legislative background for individuals with psychiatric disabilities to go on to be protected under the law if they choose to disclose. Reasonable accommodations make it possible to apply the law in a practical way so that more individuals with psychiatric disabilities can go on to be successful and satisfied with their employment situation.

Supported Education

A second factor to facilitate recovery that has been demonstrated through both qualitative and quantitative research is the supported education approach (Anthony et al., 1990). Anthony and Blanch (1987) state that historically, the treatments for

individuals with severe psychiatric disabilities were medically based and symptom focused. Kirsch (2002) calls for a shift from an individual pathology model to a dynamic relationship between the work, the environment, and the people and advocates for a greater understanding of how to facilitate the process and outcomes of work integration. Anthony and Blanch (1987) endorse a supported education model based on direct skills teaching in which interventions are focused on behavior rather than exclusively on thoughts and feelings.

The supported education approach uses rehabilitation technology. Farkas, Cohen, and Nemec (1988) state that the goal of rehabilitation technology is to improve the functioning of an individual with psychiatric disabilities by breaking down everyday tasks so they can be understood and replicated. The direct skills teaching strategy developed at Boston University's Center for Psychiatric Rehabilitation is based on an educational model of "teaching as treatment" (Berenson, 1976). Direct skills teaching techniques include the following: orienting the person to the process using comprehensive explanations and descriptions of skill performance; demonstrations of performance of the type of skills and competent behaviors; and demonstrations of the behavior in the applied environment (Nemec et al., 1992). Another critical component of direct skills teaching is the use of constructive feedback and critique involving the interactive discussion of strengths and weaknesses of skill performance with encouragement and reinforcement. Skills programming, the identification of barriers to successful skill performance, uses action steps and self-rewards to eliminate barriers to skills performance once the individual has learned the skill (Nemec et al., 1992). Skills are defined as observable, measurable, and teachable behaviors (IAPSRS, 1994).

Direct Skills Teaching (DST) is used to assist in changing or developing individual students' behaviors. This DST process helps participants identify and focus their existing capacities and develop them in a way that supports their own value systems and is consistent with the expectations of their chosen environment. Nemec, McNamara and Walsh (1992) state,

> skills development is goal-oriented, focusing on successful performance of the skill by the learner in identified circumstances. The skill must be generalizable from the classroom to the real life circumstance in which it is required. (p. 16)

The supported education approach is based on a theory that teaching transcends the classroom and extends far beyond the memorization of facts or reiteration of the materials given. As educational psychologist and reformist John Dewey (1916) stated, "education is not preparation for life, education is life itself" (p. 79). He maintained that the purpose of education is to enrich the participants' experiences and positively impact the lives of others. Lave and Wagner's (1991) theory of situated learning builds upon John Dewey's idea. According to this theory, the mere state of passively receiving knowledge "transmission" is not a valid form of learning because the person is not situated in a context, participating in an activity, or belonging to a community (Lave & Wagner, 1991).

Research on Supported Education

The studies examined below demonstrate the necessity of actively engaging participants in their own development and vocational recovery as well as documenting a need for further in-depth qualitative research in this area. There is a growing database on the efficacy of supported education. The purpose of examining this research is to

clarify the effectiveness of what is in place to assist participants in their vocational development and recovery. This review will also help determine what could effectively be implemented in programs by identifying what is lacking. This section will focus mostly on research of young adults experiencing severe psychiatric disabilities.

Computer and Career Training Program Study

In 1993, Boston University's Center for Psychiatric Rehabilitation, in collaboration with IBM, implemented the Training for the Future (TFTF) program as an innovative, research-based supported employment program. A comprehensive program evaluation of TFTF began after the program's pilot year in 1994 (Hutchinson, Anthony, Massaro, Rogers, and Cash, in press). Four classes with a total number of 68 students took part in the evaluation over five years. Boston area service providers referred the students and program staff interviewed them. The sample is one of convenience because individual's self-selected into the program. The inclusion criteria were a documented psychiatric disability, a strong desire to participate in a structured-education program, an interest in working with computers, a stable residence, and an established support system. The self-reported breakdown of diagnoses was: 30% Schizophrenia, 25% Depression, 15% Post Traumatic Stress Disorder (PTSD), 12% Bipolar, and 18% Unsure. Ninety-three percent of these individuals took psychotropic medications. There were 56% men and 44% women in the program, and 83% were Caucasian.

The program utilized a one group pre-test, post-test design with repeated measures over time. Following a ten-month classroom phase, students entered two

months of internships to give them real work experience in a computer-related career. Students were interviewed quarterly at 0, 3, 6, 9, 12, 15, and 18 months using standardized assessments. The first assessment, adapted from the Ongoing Client Instrument, measured role status, financial status, mental health service utilization, and housing status. The Empowerment Scale assessed an individual's capacity to impact changes in their own lives and the lives of others. The clinical and research version of the Tennessee Self-Concept scale helped to determine students' level of self-esteem. The level of leisure activity was assessed using the Katz Adjustment Scale, forms S2 and S3. This self-report measure asks individuals to rate their levels of effectiveness in social activities both currently and in the future. The study also used the Consumer Satisfaction Scale-8 (25)(CSQ-8), which has a series of eight questions assessing overall life satisfaction.

The first objective of the TFTF program was to instruct individuals with severe psychiatric disabilities in computer skills training in a supported education environment. The second objective was to provide supported employment services to promote the students' career development. The first part of the intervention consisted of supported education for the first ten months of the program. The schedule for the classes was Monday through Friday with Wednesday being a day off. The average number of hours per day was seven hours. The second part of the intervention consisted of individual career and job development support. The average daily attendance was 90% and the percentage of individuals who completed the training was 89%.

The outcome data from this evaluation showed an 87% job placement rate with a 55% job retention rate over 90 days. In addition, statistically significant increases

were noted in measures of daily living activities and in mean quarterly income. Furthermore, a full 90% of students "strongly agreed" or "agreed" that the program was meeting their needs. Finally, 62% of students indicated that they were satisfied with their pay and 48% were satisfied with their chances of advancement in the future. Given the frequency with which people with psychiatric disabilities are placed in minimum wage or "dead end" jobs, these last two statements convey the importance of the TFTF program for providing people with opportunities to attain quality competitive jobs that offer the potential for self-sustainability.

These results support that the program positively affected many of the interpersonal, social, and financial domains of living with serious psychiatric disability. The TFTF program demonstrated that there was a marked decrease in mental health service utilization among enrolled students. Increases in non-vocational outcomes, such as sense of empowerment and self–esteem also were documented. Therefore, TFTF represents an example of successful integration of supported employment and supported education program models. Hutchinson, Anthony, Massaro, Rogers, and Cash (in press) conclude that the integration of supported employment and supported education in combination with skill development increases vocational outcomes. In an era that promotes recovery from severe psychiatric disabilities as a nonlinear and multi-faceted process, there is very little research being done on how integrated, educationally-based programs facilitate positive outcomes in multiple areas of functioning (Hutchinson et al., in press).

National Longitudinal Transition Study (NLTS)

Examining the trends in employment, wages, postsecondary education, and residential independence of youth with disabilities, the National Longitudinal Transition Study (NLTS), reported the Post-school Outcomes of Youth with Disabilities (Blackorby & Wagner, 1996). This nationally representative study sampled students in special education classes in 303 school districts across the country in order to examine the critical juncture of youth in the five-year period after high school. Stanford Research Institute (SRI) conducted this study over a period of three years. NLTS was congressionally mandated in 1983 and sponsored by the Office of Special Education Programs (OSEP) of the U.S. Department of Education. The NLTS included approximately 8,000 youth who were between the ages of 13 to 21 and in special education in secondary schools during the year 1985. The NLTS used a weighted sample that was applicable to youth with disabilities as a whole, but also separately addresses the 11 federal sub-categories, which include youth with severe emotional disturbances or psychiatric disabilities. For the purposes of this summary, the subgroup of young adults experiencing emotional disturbances or psychiatric disabilities will be addressed here (Blackorby & Wagner, 1996).

The research utilized a two-wave longitudinal design that collected full data sets in 1987 and 1990. The study used multiple data collection strategies including telephone interviews, analysis of high school transcripts, surveys of teachers and principals, and interviews with parents. The study was attempting to capture the characteristics and trends of youths' developmental outcomes and activities as they transition into young adulthood. For the purposes of this study, independent living is

defined as living alone, with a spouse or roommate, in a college dorm, or in a military housing; not as a dependent (Blackorby & Wagner, 1996).

In the results, it was reported that youth with serious emotional disturbances (SED) or severe psychiatric disabilities scored lower than all other young adults with disabilities in terms of developmental outcomes. Only 61% graduated high school, while 41% were dropouts. Forty-eight percent of the individuals were unemployed and 30% of young adults with psychiatric disabilities experienced homelessness. Young female adults with severe psychiatric disabilities were much more likely to experience pregnancy (48%) than the females in the general populations, and were far less likely than their peers to be married (Blackorby & Wagner, 1996).

The data from NLTS indicated progress in all four outcomes over the five-year period after high school for all the youth with disabilities. In all categories, however, young adults with psychiatric disabilities were not on par with their peers with other disabilities and fell shockingly behind their peers in the general population with respect to levels of education completed, levels of employment, and stable housing situations achieved, and were much more likely to become pregnant or impregnate someone and not be married. This study demonstrates the need for customized supports for young adults with psychiatric disabilities transitioning into adulthood in order to navigate this difficult transition successfully (Blackorby & Wagner, 1996).

National Adolescent and Child Treatment Study

The purpose of the National Adolescent and Child Treatment Study (NACTS) was to compile descriptive data on children with severe emotional disturbances (SED)

(Greenbaum & Dedrick, 1999). Many sources of data were used including personal interviews with the children, parents and caregivers, and teachers, plus clinical and educational records. This information includes demographic and family characteristics, (ethnicity, income, family composition), level of psychological functioning and coping skills (problem behaviors), services received (individual counseling), and outcome data (academic achievement, contact with law enforcement). The instruments were administered to children, parents and caregivers, and teachers. The instruments included a CBCL/4 Vineland Adaptive Behavior Scale (VABS) (Sparrow, Balla & Cicchen, 1984), Wide Range Achievement Test-Arithmetic and Reading (WRAT) (Wilkinson, 1984), and the Diagnostic Interview Schedule for Children-Child-Version. (DISC-D) (Costello, Edelbrock, Dulcan, Kalas & Klaric, 1998).

The design, an accelerated longitudinal design, provided cross sectional and longitudinal data spanning a developmental sequence of 15 years. The sample consisted of 812 children with SED. The age range of participants was 8-18 years of age with the median age 13.89. For the purposes of this study, age cohorts were divided into three groups: 9-11, 12-14, and 15-17 years. Data was collected annually over a seven-year period. There were six states selected to provide geographic diversity: Alabama, Mississipi, Florida, Colorado, New Jersey, and Wisconsin. Sites were either a public mental health facility or a community-based special education program. One hundred and twenty-five sites were identified and 121 sites agreed to participate: 27 mental health centers and 94 special education sites (Greenbaum & Dedrick, 1999).

Research participants were 70% White, 22% African American, 5% Hispanic and three percent Other. The majority of participants, 55%, were from two-parent

families. The participants' emotional and behavorial problems were considered severe from the beginning of the study. The distribution of DSM-III disorders was as follows: conduct disorder 66.9%, anxiety disorder 41%, depressive disorder 18.5%, attention deficit disorder 11.7%, and schizophrenia 4.7%. Multiple disorders were common, with 41% of the students having two or more disorders. Among the children with co-occurring disorders, the presence of a third co-occurring disorder rose to 66.7% (Greenbaum & Dedrick, 1999).

Results indicated that at the beginning of the study the children had serious problems in many areas of their lives and these problems did not lessen for them at the end of the study. The most concerning implications of these results are the strong degree of inter-relatedness of the problems: their longevity over time; an abundance of problematic outcomes in areas such as school, adaptation behavior, and criminal activity; and in re-admissions into mental health settings or jails (Greenbaum & Dedrick, 1999).

One of the major objectives of the NACTS was to examine the psychological and adaptive abilities of children and how they fluctuated over time. The most common service utilization was mental health utilization at 93%. Another significant outcome measure was interaction with law enforcement. Two-thirds of the children (66.5%) had at least one contact with the police because the child was the performer of the crime. Forty-three percent of the children were arrested at least once. Overall academic outcomes were poor. The assessments determined that the children lacked important academic skills and demonstrated a pattern of underachievement (Greenbaum & Dedrick, 1999).

The data demonstrated the need for comprehensive and integrated services that must be provided for an extended period of time. There will be a great cost to society in terms of loss of productivity and continued need for special services if more supportive and integrated long-term programs are not put in place. This study suggests that the transition from older adolescence to early adulthood is one of the most challenging in life. It is a developmental period in need of more in-depth study in order to determine who should be involved to properly support these young adults. Also, more information is needed on how to address the differences in age, gender, and race/ethnicity.

McGraw Center Study

The research department of Seattle Children's Home conducted a follow-up study to capture the psychosocial course of young adults with psychiatric disabilities discharged from psychiatric residential treatment facilities (Vander Stoep, 1992). The study took place at the McGraw Center Psychiatric Residential Treatment Facility. The McGraw Center Study followed 87 adolescents with severe psychiatric impairments discharged between the ages of 15 and 17 and discharged from the first long-term residential treatment facility in Washington State when they were in the years 1981-1987. The age of onset of the psychiatric disability was between 13 and 18 years of age. This five-year longitudinal assessment was trying to determine at what point young adults with psychiatric disabilities are most susceptible to hospitalization, unemployment, and residential and financial difficulties. It also sought to pinpoint factors that may be linked to better or worse outcomes (Vander Stoep, 1992).

Unlike the three previous studies, the National Longitudinal Transition Study (NLTS), the National Adolescent and Child Treatment Study (NACTS) and The Young Adults in Community Study (YAICS), which will be discussed next, the McGraw Center Study focused only on young adults with severe psychiatric disabilities. In order to qualify for this residential treatment facility, applicants had to be within the normal range of intelligence and have a severe psychiatric impairment accompanied by a clear diagnosis (Vander Stoep, 1992). To put the level of severity of the young adults' psychiatric disabilities into perspective, less than five percent of the general population was diagnosed with schizophrenia. In this sample, 29% had diagnoses of schizophrenia and other thought disorders. The gender balance in the study was proportional with the same number of females and males. The age margin narrowed with about 85% between the ages of 16-18 years at the time of discharge from treatment (Vander Stoep, 1992).

The study interviewed participants annually for the five years following their discharge. The interviews used a life course questionnaire to assess their residential, vocational, financial, and treatment status. The study used several psychometric instruments to measure symptomology and quality of life. Outcomes captured a "year of life" from ages 17 to 20. The study sought to capture the period of time when young adults stop being part of children's services and had the option to be part of adult psychiatric services (Vander Stoep, 1992). This was an important facet of the study because there was so little data collected on the long-term course of the social, academic, vocational, and symptoms of participants, and the research was especially rare during this critical period in the young adults development (Blotcky, Dimperio & Gossett, 1984).

At five years after discharge from residential treatment, the McGraw Center Study found that nearly one third of youth had at least one episode of homelessness following discharge. Among those participants who were ever homeless during the five-year follow-up interval, each individual was homeless on average about 1.6 times (Vander Stoep, 1992). This study's data suggested that young adults with severe psychiatric disabilities are more susceptible to homelessness. Young adults with severe psychiatric disabilities who could benefit greatly from supported residential programs were significantly less likely than their peers in the general population to be in one because they were not likely to seek treatment.

The results of the study also found high rates of hospitalizations and arrests, and low rates of employment, school attendance, and vocational training. High rates of pregnancy were also found in this study. This outcome is particularly problematic because of the effect on future generations of youth born into a system that does not have the capacity to appropriately support them. The McGraw Center Study documents that the 19th year of life "holds an increased degree of turmoil for young people whose lives are often chaotic in the best of times" (Vander Stoep, 1992, p. 364). Given this outcome, Vander Stoep raised the following important question in her discussion: Other than being hospitalized, participating in outpatient treatment, and taking psychotropic medications, what are these young adults doing in their first year of adult life?

Examining the Limitations of the NLTS, NACTS, and the McGraw Center Study

The NLTS, NACTS, and the McGraw Center Study were all important for documenting and calling attention to the challenges facing this population in crisis. These three studies have shown how the transition time for young adults with psychiatric disabilities is critical. Paradoxically, at a time when young adults have the least amount of system and family resources, they are most susceptible to dropping out of high school, becoming involved in criminal activity, being unemployed, experiencing instability or crisis in their housing situation, struggling to negotiate public assistance programs, and experiencing the absence of community supports. Even though these studies have yielded an abundance of valuable data, it is important to note that each has particular limitations (Vander Stoep et al., 2000). In the absence of information about what other young adults are facing who do not experience psychiatric disabilities, it is difficult to assess what challenges are specific to young adults with psychiatric disabilities and which ones are common for this transition period. Comparing outcomes with census data has yielded information that young adults with psychiatric disabilities do not do as well as young adults in the general population. However, it is difficult to account for social class and other demographic differences with this limited information.

Another deficiency of these three studies was that they included a selection of treatment-based rather than community-based samples of young adults with psychiatric disabilities (Vander Stoep et al., 2000). In the recent National Institute of Mental Health Methods for the Epidemiology of Child and Adolescent Disorders Study, of the young adults who had both a psychiatric disorder and significant impairment, less than

one third of youths received specialized mental health treatment (Leaf et, al., 1996). Therefore, without a comparison group it was difficult to accurately access the other two-thirds of youth whose gender, ethnicity, rural/urban status, social class and severity of psychiatric disabilities influence receipt of treatment (Cohen & Hesselbart, 1993). It was difficult, if not impossible, to make inference about participants within the general population through the use of treatment studies alone. It could be argued either way that outcomes of treatment would not be as high due to selection into treatment with the most severely psychiatrically disabled -- the mere label alone could change some participants' expectations and goals for themselves. Conversely, it could also be argued that the outcomes for young adults with severe psychiatric disabilities would be better due to positive effects in treatment. In order to effectively address this research problem, community-based studies should be conducted on both young adults' experiencing and not experiencing severe psychiatric disabilities in which demographic differences are controlled outcomes.

Young Adults in Community Study (YAICS)

The community-based study of the transition to adulthood for adolescents with psychiatric disorders (Vander Stoep et al., 2000) addressed some of the limitations of the three previously summarized studies. The Young Adults in Community Study was part of the Children in Community Study (CIC). The goal of this study was to chart the course of a group of children who were representative of the general U.S. population in terms of characteristics including socioeconomic status, family makeup, and urban/rural

communities. The study also attempted to determine factors related to the onset and development of psychiatric disabilities.

The study sample was selected in 1975 using a four-stage sequential procedure to obtain a probability area sampling of representative families in upstate New York, who had a least one child between the ages of 1 and 10. Randomly selecting one child from each household, the study obtained completed interviews from 976 of the 1,141 qualified households. This process yielded an 86% response rate. The first follow-up was conducted in 1983 when 74% of the original households were interviewed again. The transition to adulthood was considered to be between the ages of 16 to 25 years of age. However, 18 years of age is a critical juncture for young adults so this age was the defining age of cutoff for this cohort (Vander Stoep et al., 2000).

In terms of the data collection in each follow-up wave, fully-structured interviews were conducted with children and mothers or the individual's maternal support. These interviews lasted up to two hours and were conducted independently and simultaneously by pairs of trained lay interviewers. In order to qualify for the study, the participants had to have a psychiatric disability in adolescence. The classification was based upon the children having a DSM-III, Axis I diagnosis of anxiety, depression, disruptive, or substance abuse disorder in 1983. The outcome measures were based on young adults' functional status. The majority of measures were self-reported by the young adult. The outcome measures were broken down into five main categories:

(1) The "secondary school completion" outcome identified if a student completed or was likely to complete the 12th grade at the time of follow-up.

(2) The "gainful activity" outcome was a comprehensive gauge that identified participants as "gainfully active" if they were engaged in part or full-time employment or education. They were considered "inactive" if they were not involved in work or school.

(3) The "criminal involvement" domain included information about whether the young adult had been in trouble with the police within the two years preceding the follow-up interview. Other antisocial and violent behaviors were also noted even if they had not been reported to the police.

(4) The "sexual activity" domain included sexual activity at the time of the follow-up interview and the number of pregnancies that the individual had contributed to or had personally experienced.

(5) The final category was the "social support" domain, which determined whether or not the person was living alone at the time of the follow-up. Various other factors of social support were also considered, including social integration and quality of interpersonal relationships (Vander Stoep et al., 2000).

The results of the first measure of completing secondary school were below par for the young adults with psychiatric disabilities. Approximately 39% of adolescents with psychiatric disabilities had not completed or were not on their way to completing

secondary school. This would make them six times less likely than other youths in the general population to reach this educational achievement. Young adults experiencing psychiatric disabilities were three and a half times less likely to be involved in gainful activity (i.e.,employed or in school). It is also important to note that the employed young adults experiencing psychiatric disabilities stated less fulfillment in their work. In the two years preceding the follow-up study, nearly 25% of the young adults who experienced psychiatric disabilities had some level of criminal involvement. This level of criminal involvement is double that of young adults in the general population. Levels of sexual activity were consistent with that of young adults in the general population, with 65% of young adults experiencing psychiatric disabilities stating they were sexually active. The more disturbing finding is that almost 30% of young adults with psychiatric disabilities had stated that they had been pregnant or impregnated someone. This statistic is nearly three times that of the general young adult population. Although pregnancy in and of itself is not a detrimental outcome, a larger percentage of young adults with severe psychiatric disabilities stated they were troubled or upset as a result of their pregnancies. There was no significant difference between the social support of young adults with psychiatric disabilities and the general population of young adults; yet young adults experiencing psychiatric disabilities were noted for frequently reporting that they lived alone.

The results of this study have demonstrated that these participants have a greater risk of not completing high school, a stronger likelihood of not being involved in a "gainful activity" such as part-time or full-time school or employment, greater job dissatisfaction among those who are working, more negative interaction with police,

and increased incidence of pregnancy, with a higher level of sadness about the event (Vander Stoep et al., 2000). This study is significant because it was a community-based study that compared young adults who experienced psychiatric disabilities while controlling for treatment utilization. The data also provided a baseline comparison group. Therefore the differences between the groups can be understood and the level of supports necessary can be adequately addressed.

Table 2. Comparison of the Young Adult with Psychiatric Disabilities Studies

	NLTS	NACTS	YIT	McGraw
Number in Study	8,408 with disabilities	812 youth with serious emotional disturbance	209 youth with serious emotional disturbance	86 youth with serious emotional disturbance
Origin of Population	Students with disabilities from secondary schools	Half from community special education programs, half from residential programs	Subsample of NACTS; half from special education, half from residential mental health	McGraw Center Psychiatric Residential Treatment Facility
Sites Sampled	303 school districts across the country	Six states	Six states	One facility
Age at Outset of Study	15 to 23 years	8 to 18 years	18 to 22 years	13 to 18 years
Length of Follow-Up	3 years	6 years	Point in time	5 years

Source: Vander Stoep et al., 2000.

Summary

This chapter provided an overview of the historical, political, social, and cultural influences on the field of psychiatric rehabilitation. The four main categories in psychological theory that shaped psychiatric rehabilitation were also detailed. This

chapter then explained the three significant ideas in psychiatric rehabilitation: recovery, supported employment, and supported education, referencing important empirical evidence that demonstrated their prominent role in the research that provided the foundation for the present study. One of the key implications of an examination of this research in recovery, supported employment, and supported education was the apparent need to study the impact of how vocational rehabilitation and supported education programs influenced the development and vocational recovery of participants. In the quantitative and qualitative research conducted so far, there is no research perspective of young adults with severe psychiatric disabilities that combines the impact of education and support on career and educational outcomes. There is also no research that asks the participants themselves what they believe would be important in their own vocational development and recovery. Therefore, the interplay of these two approaches examining the link between education and support in terms of career outcomes and that of the participants themselves when asked what they felt were critical components of their development and vocational recovery makes this research important to the participants and to future research studies. The results of this review of the literature dramatically underscore the need for further research to address the significant gaps of young adults with severe psychiatric disabilities perspectives in the literature. Further qualitative and quantitative research on the participants themselves is necessary to understand more specifically the level and types of supports that are necessary to assist young adults with severe psychiatric disabilities to successfully transition to adulthood.

CHAPTER 3

METHODOLOGY

Introduction

The goal of this study was to examine the levels of support and education needed to transition young adults with severe psychiatric disabilities into meaningful work and/or satisfying educational endeavors. The aim was to determine the role of education and support in participants' development and vocational recovery. The project enrolled 33 participants ages 16-26, who had a diagnosis of a severe psychiatric disability. Individuals who chose to participate in the research were part of the Jump Start Program. These participants were recruited into the Jump Start program from local public schools, psychiatric hospitals, rehabilitation programs, advocacy groups, and via the Internet.

This chapter consists of a description of the participants' and the populations' characteristics. The quantitative and qualitative measures are described, putting particular emphasis on the open-ended semi-structured interview survey, which was the focus of the research. The answers to the survey's questions are the central piece that elucidates the participants' experience and perception of the support and education on their vocational development and recovery. Then the procedures are described and the data processing and analysis are explained. Next, the themes are revealed and categorized under the research questions. The significance of the research is explained. Finally the research assumptions and the limitations of the study are characterized.

Participants

The study population consists of young adults with severe psychiatric disabilities between the ages of 16-26. Thirty-three participants were interviewed at baseline. The mean age of the participants' was 21. The gender distribution was almost equal. There were 17 women (52%) and 16 men (48%). Race/ethnicity of participants was as follows: two Asian/Asian Americans (6%), one Pacific Islander (3%), nine African Americans (27%), 20 Caucasian (60%), and one participant who identified as half Hispanic (3%). In terms of marital status, 32 were single/never married (97%) and only one was married (3%).

The primary diagnosis of the participants was self-reported as follows: 13 bipolar disorder (39%), eight schizophrenia (24%), six post-traumatic stress disorder (PTSD) (18%), four major depression (12%), one anxiety disorder (3%), and one attention deficit hyperactive disorder (ADHD) (3)%. In terms of the number of psychiatric diagnoses reported at baseline, 22 reported one diagnosis (67%), three reported two diagnoses (9%), and eight reported three diagnoses (24%). Thirty participants took psychotropic medications (91%).

Table 3. Participants' Primary Diagnosis

bipolar disorder	13	39%
schizophrenia	8	24%
post traumatic stress disorder (PTSD)	6	18%
major depression	4	12%
anxiety disorder	1	3%
attention deficit hyperactive disorder (ADHD)	1	3%

Measures

Qualitative Research

Semi-Structured Participant Interviews

The central research instrument was the open-ended semi-structured questionnaire. It was a qualitative instrument, which was the focus of the research. A semi-structured interview format was audio-taped to capture participants' perspectives of what education and supports were helpful and/or problematic in their own vocational recovery. In the interview, the participants were encouraged to describe and articulate what their experiences had been with education and support during the last year. Participants were also asked to explain the meaning formed about their experiences with support and education over the past year. The interviews focused the participants on answering the three research questions which were as follows: 1) What were the participants experiences with situated learning in their development and vocational recovery; 2) What were the participants experiences interacting with supports in their development and vocational recovery; and 3) What were the participants and mentors experiences with the mentoring relationship in their development and vocational recovery. When using open-ended questions, the participant's answers and the interviewer's questions went in different directions at times, depending on how the participants responded; but each participant was asked the same basic questions in the same order. Please refer to Appendix A for the Participant Questionnaire.

In terms of validity of the questionnaire, several members of my committee including Dr. Kevin Nugent, Dr. Grace Craig, and Dr. Sangeeta Kamat assisted in the reformulation of the final five exit interview questions. Dr. Dorothy Hutchinson, Director of Services at Boston University's Center for Psychiatric Rehabilitation and Alexandra Bowers, MPH, MSW, then reviewed the questions to determine their level of effectiveness and to detect any bias. Prior to the Jump Start study, a pilot study was also conducted to see if the questions resonated with the individuals with severe psychiatric disabilities. Since the pilot study was not conducted on the targeted age group of the study, two young adults with psychiatric disabilities reviewed the questions to determine the age appropriateness and relevance of the questions. The form was then changed to reflect all the reviewers' feedback.

Semi-Structured Mentor Interviews

The final part of the research was an audio-taped interview with the mentors to capture their insights and ideas about the mentoring process in a more in-depth and personalized way. The interview focused on how the mentors had been impacted by their experiences as a Jump Start mentor. The open-ended semi-structured interview questionnaire form sought the mentors' perception of the mentoring relationship on their vocational development and recovery. These questions were used to guide the mentors in talking about their experiences and perceptions. The questionnaire was used to answer the third research question, which was: what are the participants' and mentors' experiences with the mentoring relationship in their development and vocational recovery? In terms of the questionnaire's validity, Alexandra Bowers,

MSW, MPH and the researcher created a questionnaire with eleven questions to document the mentors' perception of their participation in the development and vocational recovery of their mentee or mentees. The interview form was then reviewed by Dr. Dorothy Hutchinson to detect for bias. Please see Appendix A for the Mentor Questionnaire.

Measures

Quantitative Research

Demographics Inventory

For one small component of the study, quantitative measures were also used. The first quantitative instrument used was the Demographic Inventory. This instrument obtained a baseline demographic of the population (Boston University, 2003). This instrument sought to capture changes in the participants from baseline to endpoint. The information included in this demographic inventory was participants' gender, race/ethnicity, diagnosis, housing status, educational status, and vocational status both in the baseline of the program and at the end of the program (Boston University, 2003).

Recovery Attitudes Questionnaire (RAQ-7)

The second quantitative instrument, the Recovery Attitudes Questionnaire (RAQ-7), had seven questions measuring the participants' attitudes about recovery from psychiatric illness (Borkin et al., 1998). The RAQ-7 was developed to compare

attitudes about recovery among different groups such as consumers, mental health professionals, family and the public at large (Borkin et al., 1998). The scale also measured changes in recovery attitudes over time. The original scale RAQ-21 consisted of 21 items that were based on Anthony's (1993) recovery ideas. This scale was reduced to seven questions because the goal of the scale's designers was to have a concise and easily understandable measure. The alpha coefficiency for the RAQ-21 was .838. The Cronbach alpha for the RAQ-7 was .704, suggesting this was an acceptable internally consistent measure (Borkin et al., 1998). Please refer to Appendix A for the full scale.

Interpersonal Support Evaluation List (ISEL)

The third quantitative instrument, the Interpersonal Support Evaluation List (ISEL), contained 40 questions that query perspectives about the level and types of social support (Cohen & Hoberman, 1983; Cohen, Mermeslstein, Kamark & Hoberman, 1983). The ISEL had obtained a high level of internal consistency. The Crobach alpha for the ISEL was 0.90 (Johnson, Meyer, Winnet & Small, 1999). It had also demonstrated a moderately high six-month test-retest stability coefficient, which was 0.74 (Johnson, Meyer, Winnet & Small, 1999). Please refer to Appendix A for the full scale. These three instruments have been proven to be stable and consistent over time and repeated use. Therefore, these standardized measures were also found to have content validity.

Procedures

The location of the Boston University Center for Psychiatric Rehabilitation was chosen because the study's author is employed there as the Employment and Training Manager. When the Center received a grant from the Research Services Administration, permission to add another level of research to the existing quantitative research design to incorporate the participants own voices using qualitative interview questions was approved. The purpose of the research was to engage the participants on all levels of their intellect, insight, and capacity for action and then to document their perceptions and experiences of education and support over the past year.

The procedural protocol involved a semi-structured open-ended audio-taped interview. The participants were oriented about the project, assisted in completing the Informed Consent/Assent forms, and they then filled out the self-report questionnaires. Informed consent was obtained from those participants aged 18-26 in a meeting with a researcher at the Center for Psychiatric Rehabilitation. This meeting occurred after a referral was made and the person initiated contact with the Center for Psychiatric Rehabilitation. This meeting occurred before the participant began to receive any services from the Center for Psychiatric Rehabilitation. All research methodology questions were explained during this initial meeting. An informed assent was obtained from the parents of those participants aged 16-17, as required by the law. These interviews occurred initially upon enrollment into the program and upon exit from the program and lasted approximately 1.5 hours. There was no formal psychiatric assessment or testing done in this project that focused on diagnosis or treatment. All information was requested from the participant and was self-reported unless the

participants requested that we seek further information from other sources. Please see Appendix B for a copy of the Informed Consent/Assent form.

After the Informed Consent/Assent forms were read and the participants' questions were answered regarding the form, the participant was read the questions from three quantitative measures: the Demographic Survey, the Recovery Attitudes Questionnaire, and the Interpersonal Support Evaluation List (ISEL). The interviewer then marked their responses on the surveys. The final and most significant part of the interview process involved a semi-structured interview format that was audio-taped. The open-ended semi-structured interview questionnaire form had four questions that sought the participants' perception of level of support in their development and vocational recovery. These questions guided the participants in talking about their experiences and perceptions and how they related to the three research questions. Additional questions and prompts were used to encourage the participants to explain, clarify, or elaborate on their answers. When using open-ended questions, the participant's answers and the interviewer's questions went in different directions at times depending on how the participants responded, but each participant was asked the same basic questions. Please refer to Appendix A for the Participant Questionnaire.

In the research, pseudonyms were used for the participants, and identifying information was changed to protect participants' identities. In order to present the interviews, idiosyncrasies in the participant's speech were removed consistent with the content and meaning of the participant's lived experience. Brackets [ ] were used where a word has been used to add greater clarity and an ellipsis (....) to note a break in flow of dialogue.

In the results section, the participant's own words were preceded by short descriptions that included the diagnosis and a brief background on the participants' characteristics. These summaries attempted to familiarize the reader with a small idea of the vocational lives or aspirations of the participants. It was the researcher's aim that these brief glimpses into the strengths, as well as disabilities and symptoms these participants face, would provide the reader an appropriate context for the participants' quotes. These brief descriptions depicted some of the common challenges faced daily by the participants who are struggling to balance work or school, and life in a meaningful and satisfying way.

The rights and welfare of the human subjects were protected throughout the duration of the study. There were no foreseeable risks or discomforts to the participants as a result of participation in the program or in the two research interviews. All participants chose to enroll in the Jump Start Program and some also participated in traditional mental health services as well, so that when there were unforeseen consequences of receiving recovery-oriented services, both skilled staff at the Recovery Center and the participant's treatment team attended to issues that arose. The actual participation in the data collection was expected to cause no distress, but in the unlikely event that an individual was distressed by the questions posed, she or he would have been able to discontinue participation or choose to refuse to answer such questions without jeopardizing his or her status in the program. The participant could have also requested that all data collected be destroyed without jeopardizing his or her status in the program. There were no participants in the program who chose to have his or her

data collection destroyed. This option was clearly delineated in the informed consent/assent process.

The anonymity of participants' information and opinions collected by the four instruments was maintained throughout the data collection. The following steps were taken for protecting the anonymity of the individuals participating in this study: 1) all research data was reported in aggregate form, thus no individual was identifiable; 2) research data and audiotapes were numerically coded and the master list linking participants' names to codes was kept separate from the data under lock and key; 3) all research data and tapes were kept in a locked cabinet in a locked closet at the Center for Psychiatric Rehabilitation and only the project director and research associate had access to these areas; and 4) once data cleaning was completed, the master lists and tapes were destroyed.

Qualitative Research Analysis

The study used in-depth phenomenology-based interviewing. This process was a shortened, more condensed version of Seidman's (1998) research methodology adapted for use with young adults with severe psychiatric disabilities. Seidman (1998) explains that this type of interviewing "combines life history interviewing (Bertuax, 1981) and focused in-depth interviewing informed by assumptions drawn from phenomenology" (Schutz, 1967, p. 82). Seidman (1998) continues "... the root of in-depth interviewing is an interest in understanding the experience of other people and the meaning they make of that experience" (p. 82.).

During the interview, participants' perspectives were collected on what supports were helpful and/or problematic in their development and vocational recovery. Through the questions, the participants were encouraged to describe and articulate what factors or experiences in their lives during the last year helped to facilitate patterns of success or failure. The participants were asked to explain the meaning formed about their experiences with support and education over the past year.

Twenty-six out of the 33 participants consented to a final interview. Of these 26 participants, 23 participants were currently enrolled in the program at various stages of participation, and three terminated from the program but consented to a final interview. The remaining seven participants either could not be located or refused to participate in the final interview. All 26 participant interviews were fully transcribed.

The systematic technique of data analysis called grounded theory, formulated by Glaser and Strauss (1967), was applied. An open coding process was implemented relating to the naming and categorizing of phenomena through close examination of the participant's verbal responses. This data was then broken down line-by-line, sometimes even by phrase or similar words. The responses were examined for consistent themes and issues. The two key components in this coding process were the comparison of participant's data and the researcher's process of creating meaning. Step One in the analysis was the process of taking apart a sentence and giving each part a name that represents a phenomenon (Glaser & Strauss, 1967). Step Two was a process of categorization during which themes were grouped in relations to similar phenomena. This analysis of themes showed that consistent patterns did emerge that reflected commonalities in participants' experiences with supports. These themes were then

organized under their relevance to the research questions. This process of meaning making was also enhanced by the extensive review of the literature and the professional and personal experiences of the researcher (Glaser & Strauss, 1978). The goal was to create a small glimpse of a moment in time, or a string of experiences over the period of approximately one year, to better understand the perspective of the participants.

Quantitative Research Analysis

Te overall goal of the analysis was to describe participants' viewpoints of what was important to their vocational development and recovery. As part of this study, standard descriptive statistics such as means, modes, medians, percentages, and standard deviations were computed using an established statistical package called SPSS. Charts and tables were used to visually display important statistical results. Statistical tests we conducted to answer the research question, dependent upon the level of information collected.

Significance of the Research Methodology

This research was significant because very few studies elaborate on the impact of recovery, the role of supported education, and the role of supported employment on the participants' development and vocational recovery. This descriptive research was critical to determine how to effectively transition young adults with severe psychiatric disabilities into adulthood. Earlier research lacked the qualitative component of this study which asked participants specifically and in great detail what they needed in terms of support to be successful. The research included both qualitative and quantitative

methodology, which greatly increased the comprehensiveness of the study findings. A qualitative component was the main focus of the study. A small quantitative component was included to document the traditional demographic information and to capture the participants' basic perceptions of recovery and support in a quantifiable way. Qualitative measures were used because it was hypothesized that it would generate more effective and specific information that has the capacity to truly enhance the development and vocational recovery of the participants. This combination of mixed methodologies provided an illuminating and important glimpse into the challenges and opportunities faced by the participants.

Assumptions

Based on the literature review, the research demonstrates that individuals with severe psychiatric disabilities have the ability to recover from the many consequences of psychiatric disabilities. One of the main research assumptions was that young adults with severe psychiatric disabilities have the inner strength to develop their existing competencies in a way that can enhance their lives. The research stated that young adults with severe psychiatric disabilities were poorly supported in their transition to adulthood. This lack of support already led to many problems, including homelessness, unemployment, unplanned pregnancy or parenthood, substance abuse, and criminal activity that created a financial burden on the United States (Davis & Vander Stoep, 1997). The supported educational model upholds that unfavorable outcomes were not a result of challenges associated with the disability, but are, in fact, the result of inappropriate job and educational matches that do not compliment the interests, skills,

or abilities of the individual. Since the research confirms that strength-based and recovery-oriented approaches were the most effective approaches, these statements could have impacted the researcher's ability to accurately assess the outcomes. Yet, the study used a mixed methodology of both quantitative and qualitative research so that the outcomes could be verified in objective and varied methodologies.

Limitations of the Study

A limitation of the study was that nine months is a relatively brief amount of time to study the career and educational development of a young adult's life. Although it was a critical juncture, more time was needed to capture a young adult's full potential and growth during this developmental period. The study was also limited because there was a modest sample size of 33 participants, limiting statistical power.

The data was collected from subjects using self-report measures. While this research method makes valuable contributions to the body of research knowledge in the mental health field, the validity of self-reported information is subject to scrutiny, because the participants reported the data themselves and were not tested by experts in the field, thus potentially limiting the generalizability of the findings.

The experience of being tested could have artificially raised participants' outcomes because they were experiencing the benefits of increased attention and/or support around their vocational and/or educational goals. Since this is an evaluative study and therefore there is no control group, it will be difficult to account for this impacting the participants. I was cognizant of this because I believe that heightened expectations and attention toward an individual lead to improved outcomes.

Also, due to the level of stress and challenge facing participants, the study must account for a significant level of experimental mortality or attrition. Attrition was a significant problem in programs with similar populations (Vander Stoep, 1999). This population was "extremely at risk", because they at times experience debilitating symptoms as a result of their psychiatric disabilities, including depression, anxiety, suicidal thoughts, and hallucinations. Therefore their participation in the research was severely hampered. To account for this, the research included in the definition of participation any level of contact with the program. The study maintained that the ability to meet the participants' at their readiness level and to acknowledge the participants' perspective on their capacity to be involved in the program was critical to the participants' development and vocational recovery.

CHAPTER 4

THE RESULTS SECTION

Introduction

This chapter provides a presentation of the data collection results as they relate to each of the research questions. In the qualitative section of this study, which was the central focus of the research, much of the data was revealed using quotes from the participants and mentors in the study, which were then analyzed to help interpret and draw out the meaning-making process of the participants. Nine themes that emerged from the interviews were closely linked to the research questions, so they were explained using the research questions for organization and clarity. For the quantitative portion of the study, the results were documented using the Recovery Attitudes Questionnaire and the Interpersonal Support Evaluation List.

The participant's revealed nine significant themes throughout the research, which were as follows:

1) Many participants wanted situated learning experiences.

2) Many participants desired tangible supports and hands-on learning opportunities.

3) Many participants sought ways to take positive steps toward their own recovery.

4) Many participants needed opportunities and places for safe transitions.

5) Many participants respected the role of professional support in their lives.

6) Many participants struggled with the role of family in their lives.

7) Many participants welcomed the role of staff support in their lives.

8) Many participants valued peer support in their lives.

9) Many participants preferred peer role models and support in the form of a mentor.

Table 4. Nine Themes that Emerged from Participants

1. Many participants wanted situated learning experiences.
2. Many participants desired tangible supports and hands-on learning opportunities.
3. Many participants sought ways to take positive steps toward their own recovery.
4. Many participants needed opportunities and places for safe transitions.
5. Many participants respected the role of professional support in their lives.
6. Many participants struggled with the role of family in their lives.
7. Many participants welcomed the role of staff support in their lives.
8. Many participants valued peer support in their lives.
9. Many participants preferred peer role models and support in the form of a mentor.

Participants Themes Organized by the Three Research Questions

The themes were compared to and matched to the initial research questions according to their relationship to the content of the questions. The research questions (Q) are listed below with their corresponding theme (T) in a number list.

(Q1) What were the participants' experiences with situated learning in their development and vocational recovery?

(T1) Many participants wanted situated learning experiences.

(T2) Many participants desired tangible supports and hands-on learning opportunities.

(T3) Many participants sought ways to take positive steps toward their own recovery.

(Q2) What were the participants' experiences with interacting with supports in their development and vocational recovery?

(T4) Many participants needed opportunities and places for safe transitions.

(T5) Many participants respected the role of professional support in their lives.

(T6) Many participants struggled with the role of family in their lives.

(T7) Many participants welcomed the role of staff support in their lives.

(T8) Many participants valued peer support in their lives.

(Q3) What were the participants and mentors experiences with the mentoring relationship in their vocational development and recovery?

(T9) Many participants preferred peer role models and support in the form of a mentor.

Twenty-six out of the 33 participants consented to the interview. Of these 26 participants, 23 participants were currently enrolled in the program at various stages of participation, and three had terminated from the program but consented to a final interview. The remaining seven participants either could not be located or refused to participate in the final interview. These seven participants had withdrawn from the program for the following reasons: one participant moved, two participants had

insurmountable problems with transportation, three participants had to be hospitalized, and one participant left to be part of another program.

Employment Status of Participants at Baseline

The employment status of the participants at baseline was as follows: there were six participants (18%) working in independent competitive employment, one participant (3%) was volunteering and 26 participants (79%) were not working. Examples of types of jobs held by participants were as follows: waiter, dishwasher, cashier at a bookstore, landscaper, writing tutor at a clubhouse, counter person, cook and volunteer. The number of hours per week varied from two hours to 36 hours with a mean of 16 hours per week. The hourly wage ranged from $2.62 per hour to $10.00 per hour with a mean hourly wage of $7.27.

Table 5. Employment Status of Participants at Baseline

Working-independent employment	6	18%
Working–supported employment	0	0%
Working-employment Internship-unpaid	0	0%
Working-volunteer (unpaid)	1	3%
Not working	26	79%

Employment Status of Participants at Endpoint

The employment status of participants at endpoint was as follows: 13 participants were employed; of those employed nine participants (35%) were in independent competitive employment, one participant (3%) was using a job

coach/supported employment, and five participants (19%) were in unpaid employment internships. One of the participants (3%) was in both paid employment part-time and in an unpaid employment internship. Twelve participants (46%) were not employed at endpoint.

Table 6. Employment Status of Participants at Endpoint

Working-independent employment	9	35%
Working–supported employment	1	3%
Working-employment Internship-unpaid	5	19%
Working-volunteer (unpaid)	0	0%
Not working	12	46%

*Please note the percentages do not equal 100% because several participants were involved in more than one category.

Educational Status of Participants at Baseline

Educational status at baseline was as follows: one participant (3%) had less than a high school education because this individual spent the majority of time growing up in and out of psychiatric hospitals. Twelve participants (36%) had some high school, nine participants (27%) were high school graduates, one participant (3%) had obtained a GED, one participant (3%) was in community college and two participants (6%) were in college or universities, two participants (6%) had earned bachelor's degrees and 0 participants were enrolled in a GED program. Twenty-three participants (70%) were not enrolled in an educational program outside of Jump Start at this time. Fourteen participants (42%) lacked a high school diploma or Graduate Equivalency Diploma (GED). Twenty-three participants (70%) had received special education services.

Table 7. Educational Status of Participants at Baseline

Less than High School	1	3%
Some High School	12	36%
High School Graduates	9	27%
GED	1	3%
In GED Program	0	0
Enrolled in Community College	1	3%
Enrolled in College or University	2	6%
Bachelor's Degree	2	6%

Educational Status of Participants at Endpoint

The educational status of the participants at endpoint was a follows: three participants (12%) were enrolled in the Jump Start GED program at endpoint; two participants (9%) enrolled in high school at baseline and both participants (9%) stayed in high school at endpoint; two participants (9%) were enrolled in college or university at baseline continued at college at endpoint. One participant (3%) enrolled in community college at baseline and this participant (3%) remained in community college at endpoint. One participant (3%) started college during the program but then dropped out. In addition, two participants (9%) started community college during the program and these participants (9%) were still enrolled at endpoint. The remaining six participants were not engaged in educational or employment pursuits, but were actively involved in increasing their 'readiness to change,' which will be further explained in the discussion section.

Table 8. Educational Status of Participants' at Endpoint

Less than High School	1	3%
Some High School	12	36%
High School Graduates	9	27%
GED	1	3%
Enrolled in GED Program	3	12%
Enrolled in Community College	3	12%
Enrolled in College or University	2	6%
Bachelor's Degree	2	6%

Results of Research Questions

Results of Research Question One

Under the first research question: What were the participants' experiences with situated learning in their vocational development and recovery? The themes that emerged from the participants were as follows: (T1) Many participants wanted situated learning experiences, (T2) Many participants desired tangible supports and hands-on learning opportunities, and (T3) Many participants sought ways to take positive steps toward their own recovery. These three themes are explored below using participant quotes to further clarify and elaborate on the research question.

Theme One: Situated Learning

The most significant theme that emerged was the participants' desire to have the opportunity to develop their skills in a situation or opportunity as close to the actual

setting as possible. This type of learning is called the theory of situated learning. According to this theory, passively receiving knowledge, known as "transmission", is not a meaningful form of learning because the person is not situated in a relevant context, engaged in an activity, or belonging to a group (Lave & Wagner, 1991). Situated learning was applied throughout the Jump Start program by involving participants in either an interactive classroom, educational, or employment setting. These participants reported that they did not idly sit and absorb the material. These participants were challenged to participate, as well as create the situations or at least the groundwork for the opportunities that they sought. Examples of such opportunities included: mock interviews or role plays, volunteer opportunities, and internships or jobs to develop competence and self-confidence. Participants learn best in concrete, specific, hands-on learning situations; a theme closely connected to the idea of situated learning.

However, more specific to situated learning was the second overarching theme. This second theme was the participants' desire for concrete hands-on learning opportunities. The participants revealed that they were looking for practical, hands-on support, customized to their level of skills and abilities, and that these be provided to them in a personal and positive way in the context of a supportive relationship. Participants expressed in their interviews that they wanted "direct plans" to "have something to do," and to be "part of the process."

Miranda. The first participant who talked about situated learning, Miranda was a 21-year-old white woman. Miranda was diagnosed with post-traumatic stress disorder. Miranda resided in a psychiatric hospital. Miranda had difficulty

understanding the expectations of life outside the hospital setting. Miranda explained that her main focus of being in the program was not her career goals. Miranda stated:

> In the beginning, the classes were very helpful and interesting, but I just got caught up in my own thing. Things kind of got too much at the time. But it was cool because I learned different skills that I did not know. I formed some friendships. I think at the beginning it (the career class) was too much about career goals, or whether I wanted to go back to school. It was something I was not looking for at this point in my life. It turned out that way at the end. Doing resumes was cool. I liked sitting with each other and going back and forth. The role-plays were fun, but kind of hard. Sometimes I was distracted, but I tried to focus. There were so many things going on in my life.

Although Miranda understands that developing her interpersonal skills will also help her become more employable, she was only concerned with connecting with others in the program. When asked about her experiences with her development and vocational recovery over the past year, Miranda stated, "I guess I notice that I kind of have to balance being with people I like. My head has been filled with how to balance relationships and boundaries in certain settings." Miranda stated that she was developing and trying out social skills and relationship-building in a supportive environment. When asked how she developed these skills, Miranda responded

> I had conflicts and tried to help myself with it. That's not how I wanted the program to be. I kind of pulled back. This (the Center) is not supposed to be a therapy setting. It really helped me – it taught me about all different types of relationships.

Miranda desperately wanted to feel a "sense of belonging." In her first interview for the program, she stated she did not have any friends. Miranda noted that the Center taught her about "all different types of relationships." Miranda explained that she learned a lot about relationships through "trial and error. Just being in relationships with new people. I also learned what I didn't like. I always knew that, but now it's more real for me; more

tangible. There are so many opportunities out there that I think I have the skills for." Learning about relationships and testing out her social skills in this way was an example of situated learning. Miranda stated that her main goal was learning how to connect in genuine and appropriate ways with her peers, her mentor, and the staff in a way that was different from a "therapy setting". This process was difficult for her since she has spent most of her life in a psychiatric hospital, where the expectations are completely different. Miranda explained:

> I like the activities part. That was always good. Being involved in the community. Like when we went volunteering. I like to make an effort to help others. It gives me a sense of belonging. Like not just here, but in the world. There are so many questions, like 'do I have a place?' Now things kind of go as they go. I don't dwell on them.

For Miranda, the skills and activities she participated in the classes were not nearly as important as trying to find out who she was and how to relate and connect to others in ways that were comfortable and safe for her. Miranda explained:

> I've learned a few things that I am able to do better than I thought I'd do. Also, that I have the ability to form relationships and now if it's getting too stressful for me or the other person, being able to communicate that and not hold it inside, the ability to connect to people in general.

This was a very common struggle for participants who have experienced extreme levels of sexual, physical, or psychological abuse. It was difficult for participants to develop and maintain healthy boundaries that allow for trust to develop and a sense of connection at a manageable pace. When asked about any experiences outside of Jump Start that had made an impact on her, Miranda stated:

> The commute. It was scary to get here, taking the T and seeing all the people. It was the area, also. It was sort of like a new part of the city for me. It boosted my self-esteem to be able to do it, though.

Tom. Tom was a young African-American man. Tom always has his head down. Tom lived in a group home with other young adults with severe psychiatric disabilities. Tom was diagnosed with bipolar disorder, obsessive-compulsive disorder and attention deficit disorder. Tom had difficulty paying attention in class and often zones out during the discussion. He struggled in many classes and often felt angry when he could not comprehend or follow a lesson in class. He wore baggie pants and large sweatshirts. It was rare to see him around without his headset on. He kept to himself most of the time. When he spoke in class it was about his desire to make money and be out in the workforce. When asked what have been the most helpful things in Jump Start classes, Tom responded, "the computer class, because now I know how to use Microsoft Excel." When asked was there anything that has made a big impact on him over the past year or helped him in some way, Tom responded, "I guess the computer class is going to help me with my being an engineer." When asked how this fits into his career goals, Tom replied, "I want to do engineering work, and to work the control panels. You need to use a computer to type in everything to program it." When Tom was asked how this fit into his career goals, he stated, "You have to take a basic engineering course. I need to take a basic statistics course and the engineering course was one step above it so I have to take the basic statistics course before I take anything about engineering, like a stepping stone."

Tom stated that the Excel class was helpful to him because he wanted to become an engineer. Tom believed the classes were valuable because they directly related to his future vocational goals. Tom stated that the Jump Start program was "like a stepping stone" for him which was a familiar theme as was demonstrated in many of the other

participant's quotes. Many participants were looking for a new way to learn hands-on, concrete skills like computers, which they could use to make them more marketable in the workforce. As Tom expressed, it was very important to him that he was working. Tom explained, "I don't know. I guess I've been working. I guess it's just going back into the business field. The environment is making me happier and the fact that I'm getting paid, it's not just a volunteer thing." Tom felt happy, proud and has a deep sense of satisfaction that he was working and not sitting at home and watching TV. Tom stressed, "I'm working, and not sitting there at home, eating chips and watching TV. That doesn't interest me." Tom continued, "I guess I'd have to say it's the paycheck and interacting with customers. I like that." Tom was situated in a context that was respected and valued by others. He had never had a paid job before entering Jump Start. Although Jump Start did not get him the job, Tom stated he felt more confident and sure of himself after becoming comfortable at the program. Tom developed his readiness to be more actively involved in his vocational aspirations through Jump Start. Tom was so excited that he was not just volunteering, but being paid for his efforts. He had a purpose and a paycheck and felt that he was taking steps toward his goals. Tom had a job coach that helped him be successful at his job stocking shelves at a bookstore.

David. David was a young white man. He has a small goatee and two earrings in one ear. He was diagnosed with bipolar disorder, which he believed has contributed to his lack of confidence and his reluctance to interact with people. He said his mother really knew him and let him be who he was. He explained that his mother was very supportive. He thinks his father wants him to be the son who was on the football team

and got great grades in math. David wanted to be an architect. David explained that he had an experience in high school that supported and validated his career interests. David stated he "was always interested in buildings. Then as I got older, I got more in a focused area cause I took some classes in Art and Architecture. I found it really interesting."

David stated that he enjoyed developing his skills acquisition in his preferred learning situation. He was excited to be doing the actual activities like answering the phones and obtaining relevant information for the job. David stated that he was using this internship as a launching point for what he wants to do. David also stated the importance of having a safe learning space to test out his skills and his readiness to pursue his career goals. David saw this internship experience as a confidence and competence building situation that would help prepare him for college. David saw this internship as the closest thing to the actual environment, which would help him better prepare for the next steps in his career path. When David was asked what kinds of activities that he did during his internship he stated, "Answering phones and getting building site information, or going out visiting building sites. So that will help me for my job, kind of like before I go to college, get the experience actually being there."

David explained that he evaluated his behaviors continually and made changes to best suit his various learning situations. David talked about developing a sense of confidence; that if he applied himself he knew he could succeed. Throughout his interview, David was referring to the first theme of situated learning developing. For example, David stated, "I practiced in classes a lot here." When asked if there was anything over the past year that influenced him, David stated:

> It probably happened this summer. I've kind of changed the way I've acted. I kind of became more outgoing than I was before. Before I was kind of more shy and then I decided I was going to talk more. The thing just ended up working better. I was just kinda more self-advocating for myself. That's probably the main thing.

When asked what made the change, David replied, "I figured that I could do better if I stood out more in class and that I'd feel less nervous if I talked to kids more and made things go better if I decided I'm going to do it. It worked out pretty good." David stated:

> To kinda stick with something, you'll get better. Like doing some of the computer classes. So many times I wouldn't be getting as much and I stuck with it and ended up doing pretty good. Just sticking with things and not giving up, it helps a lot. Keep going with it.

This sense of empowerment cannot be taught in the classroom, but the environment or situation can be created to be conducive to its development. Therefore, David said that he used situated learning to develop his coping skills and a sense of increased determination.

Amanda. Amanda was a 20-year-old woman. She was diagnosed with obsessive-compulsive disorder and attention deficit disorder. One of her more prominent symptoms was that she obsessively picked at her arms. She was an intelligent and artistic young woman. She attended Berklee School of Music. She explained that she struggled with psychiatric symptoms throughout her childhood. Amanda was a musician who used music both to enhance creativity and to foster self-awareness. She wrote and performed music. Amanda stated that she feels that being at Berklee was a really important step for her. Amanda stated, "this year was a real step forward. Going to Berklee College of Music." Amanda revealed that she does not feel out of place in the college situation because other people may have ADD at college, too,

and different people have forgotten their books and gotten confused while attempting to follow the class. Amanda stated that people in college are just like her, not different or better than she is. When asked why going to Berklee was important to her, Amanda stated:

> I think other people there have ADD, too. Different people have forgotten which book we were covering, or which class, and confused the rest of the class. I had people think that I'll be really good in academia, my grandfather, definitely. In some ways, my writing is a bit scattered. I think I have some natural talent in essay writing. Some of it is hard. From fiction writing to essay writing – it's hard to differentiate when you express your own opinion. But that I can handle it as much as I have is just amazing. I've been able to handle situations that were really heavy, and taking care of this nervous energy – doing deep breathing. I have done things not to be over-stimulated. Being able to walk home with stopping at a bookstore or taking a long, long walk. I've been handling it more. It's just something I realized that I needed to work with on a daily basis and not get frustrated.

Amanda felt that academia could be the right place for her. She expressed that she was situated in a place that is both comfortable and challenging. She stated she was still struggling with her issues of how to handle nervous energy and how to avoid becoming over-stimulated. She was both acknowledging her progress and her level of frustration over what she needs to continually work on. Amanda stated that she liked specific interactive learning activities like conflict resolution and interviewing, but overall she did not find the Jump Start classes very helpful. She liked the classes that focused on specific skills that practiced things she was actually preparing to do in the real world. The tasks like conflict resolution and mock interviewing had value for her because they had real meaning and practical application in her life. Amanda stated:

> Conflict resolution was helpful. Interviewing was helpful. Going out and doing it helped to make it easier. Not real high stakes, you don't have to get all dolled up, it's a chance for me to practice. I think it's helped me

> nail the interview I just did the other day. Much better than having my grandfather help me.

The set up of the class did not work well for her. Her learning style was geared toward small groups or more one-on-one individual learning. Amanda expressed that "having all these people in the room who have all kinds of different focuses, who were going all over the place; I had a hard time being in that kind of energy." Amanda revealed that she felt more comfortable and intellectually on par with classes at Berklee. She stated that her personality and learning style was much more suited to "academia" which was her desired learning situation.

Rudy. Rudy was a shy and isolated young white woman of 19 years old. Rudy was diagnosed with paranoia, schizophrenia, anxiety, and depression. She hated the Jump Start classes and looked tortured every time she entered the Center. In an attempt to discover the source or alleviate some of her anxiety, an instructor sat down to ask her what would be helpful in her development and vocational recovery. She stressed that she had no desire to come to the Center but still wanted to be part of the program because she enjoyed meeting with her mentor. She wanted more friends and an opportunity to be out in the real world. After going over various internship possibilities, she decided she wanted to intern at a radio station. Rudy admitted that she did not like the Center at all and this was apparent because she hardly ever attended the classes. Rudy was often silent in the classes and, for the most part, did not engage in any of the class activities. The one activity that she actively participated in was the mock interviewing and she stated that particular activity was helpful to her. Rudy stated, "I remember there was one class on interviewing and you (the interviewer, Kim) said what they were like. I thought that was pretty helpful." Rudy explained that the classes

would have worked better for her if the participants, "worked in groups a little bit more. It's better when you have a small environment, not like the whole class you are working with. For people interaction, it's the small group that helps. It's safer."

In contrast to the classes, Rudy was extremely happy with her internship because it was the setting she requested and she loved being connected to that environment. Rudy stated that her internship at the radio station helped her reconnect to aspects of her life other than her family. Rudy commented that the internship gave her a social outlet independent of her family. It allowed her to "have a life" and to interact with people who knew nothing about her psychiatric disability. She said this internship significantly changed her life. When asked about her internship experience at a radio station, Rudy responded:

> I liked it a lot. I'm actually still kind of involved in the station a little bit. I'll still get emails from them about different events going on. I'll go with my friends to different events. <u>It's been helpful being out of the house because I've got a new perspective on things and I think less about what I'm recovering from and more about the present moment.</u>

Making the trip to Cambridge on the train by herself empowered her. Making cold calls helped her get over her difficulties with social interaction and her intense fear of the phone. She said it was a safe way to interact with others that was not too intimidating or intrusive to her.

Rudy noted that after she interned at a radio station she became less isolated and withdrawn. Rudy was situated in the perfect context for her to use skills that she had not used since she had to leave college due to her psychiatric disability. Rudy stated "I think it's getting away and being put in an environment where I can be successful." She was able to deal with her phone anxiety, which had been a big problem in her life, and

actually make calls for the radio station. When asked what activities she did at the radio station, Rudy stated, "I made phone calls to people. Mostly it was phone calls. I mostly called people to tell them about events on the phone. A very good phone experience." Rudy explained that because it was the actual setting that she was able to push through her fears and anxiety and perform the skills necessary to stay at the job. Rudy commented that she was able to do this because she started to get a sense of what it was like to be successful again and she was tired of sitting at home feeling disconnected and scared. Rudy stated that the internship allowed her to almost feel well before she felt totally well - sort of fake till you make it. When asked what she had learned about herself during the past year, Rudy replied, "I think I learned that I am capable of doing more things than I thought I was." When asked what helped her come to that conclusion, Rudy explained, "Well, I've been successful academically and socially this semester, so that kind of helped me come to that conclusion." After returning to Colby College, which she had dropped out of two years earlier, she continued to stay connected to this radio station because it made her feel like she had a social life. She even invited some of her college friends to events connected with the radio station. It helped her cover up or avoid going into detail about the time when she dropped out of college and engaged in isolating behavior.

Jennifer. Jennifer was a 21-year-old African-American woman. She was diagnosed with depression, attention deficit disorder and obsessive-compulsive disorder. Jennifer explained that she liked to go clubbing and have a few drinks. She was very open and has lots of friends. She stated that she loved writing in her journal

and wrote whenever she got a chance. She has a close friend who was a young man with whom she plans to live with "as a friend".

Jennifer dropped out of the program after only two months. She was unemployed for a while then she found a job that she loved. Jennifer worked at a small shop selling different scented candles in the North Shore. She loved interacting with the customers and explaining all the different functions and purposes of the candle. When asked if there was anything outside of Jump Start that made an impact on her life Jennifer responded, "I have a job now. That has been very helpful." Jennifer expressed that the job was a large part of her development and vocational recovery because it was a positive step in her life. Jennifer talked about the respect and acknowledgement that she received at work that meant more to her than getting paid a higher salary. She loved getting a paycheck, but what was really important to her was having a supportive environment where she felt safe and comfortable. Jennifer stated that it was important to her that her boss was the "nicest boss" she had ever worked for. Jennifer commented that her boss treated her "like an equal, which is really important and just everybody I work with is just so wonderful." Jennifer explained, "I don't get paid top dollar, but I don't mind because the people are just so much more with it." Jennifer stated that she was situated in an environment where she felt that she was appreciated for her contributions at work, which helped her to be successful and satisfied at her work.

Theme Two: Tangible and Concrete Learning Opportunities

Alison. Alison was a young African-American woman who was 17 years of age. Her hairstyle was different every time she entered the program. She frequently

changed the length, the style, and even the color. She was diagnosed with bipolar disorder. She had a strong connection to her mentor and worked hard with her on her career exploration and development goals. Alison utilized the program to find her career direction. Alison was working full time, and was hoping to pursue a career in education.

Alison talked about the importance of having concrete, hands-on activities that she could physically connect to. Alison stated that "I think my favorite class was the wellness class. The class on how to take care of ourselves when we were the only ones there." Alison explained that she greatly valued learning specific strategies and techniques that she could readily apply to her life in that moment. For her, the wellness class really resonated with where her readiness level and attention were directed. She wanted to learn more about how to "recognize early warning signs", different ways of "expressing our feelings" and "expressing relaxation techniques".

Alison shared that her favorite activity in class was creating an emergency box for when she needed to take care of herself. She loved the idea of physically creating something she could personally use at home with candles, pictures, poems, or candy that could help her feel better. It was a strategy that put her in more control of her own well-being and care-taking. Alison clearly enjoyed the process of learning while doing which is the premise of situated learning. Situated learning is practicing and doing the actual skills, such as creating an "emergency box" to help a participant cope during difficult times. Alison stated:

> I remember there was one project where we were to make like little emergency boxes, things that would help us feel better. We would put pictures or candy or poems, things that would make us feel good. Colors, maybe a candle that had a certain fragrance to it. One of those

> pick me up treasure boxes. I really liked that. I loved doing the collages and sort of exploring through art what we hoped to become and what we want to be. Exploring who we are right now and where we want to go. Learning relaxation techniques. I thought that was a great course.

Alison, like many other participants, stated it was difficult for her to sit and talk about her future in abstract and theoretical ways in class because her mind would wander and she would often get caught up in her thoughts. Alison expressed:

> The career class I thought was good. Sometimes I thought that was a little hard for me to follow and stay motivated in because it was a lot of talking and a lot of conceptualizing. I like to work with my hands; I'm more of a kinestic learner. I wish there were more around the interview skills. Maybe done several (interview) classes throughout the course. Maybe not necessarily all grouped together. But possibly spread out. I still keep that interview sheet and I look at it once in a while.

Again, Alison speaks to the importance of having concrete tasks involving the participants in a very hands-on and active way in the career classes. Alison really liked the interviewing skills because they were done in a concrete and interactive way with each participant doing a mock interview and the other participants giving specific constructive feedback in the moment. She also wanted the interviewing skills more spread-out so she could absorb them at a slower pace and have more opportunity to practice them over an extended period of time. When asked how to make the Jump Start classes more hands on and interactive, Alison responded:

> Have students sort of come in and bring presentations. I know sometimes I learn best when I'm teaching a subject. Maybe there is a way to get a discussion going about people asking about different career goals. Each person over the week think of an idea and bring in their thought or perspective to share. That is something the students and the mentors could work on together over the week.

Alison talked about her hope for a better future. She expressed that the program "brought back her sense of self-worth" because she realized it wasn't a "unique illness"

and that "it was still possible to succeed in life." Being situated in the context of the Center allowed her to understand that her diagnosis had a place in her life, but it was not her defining factor, nor was it going to limit her dreams. She was able to interact with lots of individuals in the recovery process and understand her "personal puzzle" of who she was and what she was capable of being. She stated that the Center was a "great transition incubation to get well again and give me encouragement and motivation to get back on my feet." Alison stated that she thought of the program as a safe transition, a place to develop greater self-awareness and self-acceptance. Alison was struggling for greater understanding of herself and how she fits into the world. Alison stated that she was searching for ways to cope and that this situation helped her move forward in her development and recovery journey.

David. David agreed with Alison about having tangible projects to work on that were specifically geared to the participants' interests and abilities. David talked about his "own thing," creating his own web design page. He commented on his ability to develop his computer skills. David was revealing his personal sense of accomplishment and connection to the tangible materials in the classes when he stated:

> Yeah. I took Web Design I and Web Design II and it helped me start, you know, make a website. Now I've been building a web site. I'd never done that before the class. It really helped me out a lot. It's been really exciting.

David made an investment in the learning, which was a risk for him. He was excited about the prospect of the finished product of a web page. David was excited about and interested in the learning process precisely because he felt it was his "own thing." Learning was directly related to a skill, which he and the marketplace valued. When asked if he completed a web page site, David replied, "It's not up yet, but I could. All I

have to do is put it up now but, I have a lot of stuff I would like : pictures, writing, all kinds of stuff."

David stated that in the beginning the activities in the career classes weren't about trying to get a job but at the end of the program, things changed. He liked the activities toward the end around making resumes and trying to find a job. David commented:

> In the beginning we weren't really doing as much and towards the end it was more like we're going to help you find jobs or colleges and stuff like that but in the beginning it was more just talking about things in general. I don't think it was helpful. Later on it focused in more on jobs and stuff.

He thought these job-seeking activities were "very important." David specifically stated a common theme voiced by many participants. David wanted to learn interesting and marketable skills like computers, web design and career development in a hands-on detailed and concrete way that was personally relevant to him. He did not want to learn the theory or talk about the values around choosing a career. He just wanted to get a job. Making his own web page and creating his own resume were direct reflections of this specific and concrete need.

Erick. Erick was a 22-year-old African-American man. He went to college but dropped out because he has difficulty staying engaged in activities for very long. He was diagnosed with bipolar disorder. He experienced periods of extreme isolation for weeks at a time, then swings into periods of elation when he goes out with his friends for several days and night in a row, nonstop. He was soft-spoken and struggled with issues of memory and concentration. He had trouble connecting with his mentor because he kept forgetting appointments or was too depressed to actually leave his

house to meet with his mentor. He had completed a volunteer internship that he loved at the Arboretum in Jamaica Plain. He has a particular fascination with Condors. He wants to someday go out West and live in California and Oregon so he can study these birds in a more in-depth way. When asked what worked for him and what did not in the Jump Start program, Erick responded:

> I guess, a lot of it is theoretical, ideas about stuff but not like direct plans. Telling you okay go here and get a job here. Yeah, hands-on. I was also thinking about homework, that I felt that wasn't sort of a bad idea. You know having something to do. Sometimes during class you end up just sitting there and you kind of like aren't getting anywhere.

Erick was voicing his frustration with the level and type of support he was receiving. Erick wanted concrete and specific help in looking for and actually obtaining a job. He stated he wanted to be involved in the process. He actually wanted homework to do when he was not in class if that would help bring him closer to actually finding a job. He wanted specific step-by-step instruction in detailed mini-steps on how to get a job. The class was talking about how to get a job but he wanted to know what actions he could personally take right now to get a job that he would actually enjoy doing. He wanted to be situated in a learning environment that was directly related to his vocational goals.

Jessica. Jessica was a nineteen-year-old white woman. Jessica made many friends through the program. She expressed that she loved hanging out, going out and listening to music. She experiences post-traumatic stress disorder, depression, and anxiety. She also used music and drugs to take away the pain that she experiences. She commented that when she was at home she spends hours in her room listening to loud music and rarely interacted with her parents or her younger brother and sister. Jessica

expressed that it was not only the kinds of supports that one interacts with but the level and pace of the supports that was also critical in her development and vocational recovery. Jessica stated that overall the classes were good but a little slow. Jessica explained:

> The computer classes were very helpful. They were a little bit like, well, like from the teaching aspect and stuff like that were a little bit slow. But good information and everything but like, I like more hands-on things. The career class was good. I mostly would like to interact like the past couple days we've been doing posters and stuff like that. Like more hands on stuff than just talking about stuff.

Jessica pointed out that the skill level of the computer class and the pace was a little lower than where she would have preferred it to be. Jessica stated that she enjoyed the concreteness of the learning activities like the collages because she felt the person "can learn more about themselves and the other people that way". She liked "doing stuff while learning." Jessica also liked when the speakers came in to talk about topics that were relevant to her and engaged the class in interactive activities.

Frank. Frank was a young white man. He was diagnosed with schizophrenia. He had lots of imaginary friends and feels deeply troubled when they are missing or not supportive of his actions. Frank explained that the voices in his head were the worst when he was listening in class or trying to read silently to himself. He explained that the voices were like a running dialogue in his head that he must simultaneously acknowledge and then ignore. He shared that it was very tough to focus in the classes. Sometimes in class, Frank openly admitted that he could not concentrate on that day. Later on in private he would explain to an instructor that the voices got too difficult to control. Frank stated his goals succinctly. Frank commented, "I just want to get the GED so I can go to college, plain and simple." Frank wanted to know specifically how

we could help him get a job. Frank remarked, "I'm looking for jobs now. I went to McDonalds, Marshalls, and D'Angelos. I want to know if you all can help me get a job?" Frank wanted concrete, practical hands on help finding a job that will bring him further along in his development and vocational recovery.

Bob. Bob was an Italian-American man who was 21 years old. He was from a close knit family that lived in the North End. He was a hard working young man who loved to eat, socialize, and be part of the group. He was always willing to lend an ear, a supportive shoulder or a hand to any participant in the program that needed his help. He continually looked for ways to connect with others and/or contribute to the program. Bob was diagnosed with schizophrenia but his symptoms have been well controlled through medication. He came from a long line of masons in a thriving family business but has chosen to be a teacher where he feels his skills can best be used to help others. Bob wanted to be a teacher and was taking courses at a community college to obtain his teaching certificate. Bob expressed that he enjoyed, "tuning up on some of my interviewing skills." Bob commented that hands-on and concrete learning was the most effective way for him to learn. Bob wanted the classes to be about practical skills acquisition with tangible products and results to be produced from the class. For example, Bob remarked, "I liked turning my resume from a three page resume to a one page. My resume was decent, it got me where I was, but getting it down to one page definitely increases your chances." Bob suggested that the class take the "acting" and "role-playing" into the real life job-hunting situation. Bob remarked that the participants should:

> Just going up and down the street, going to Downtown Boston, just acting and role-playing. Going to a store and asking for interviews. I

> think that would have been great. Just pretend like you want the job, fill out the application, talk to the manager, whatever. And then if you get it, accept it if you want. Or you can just say 'I'm sorry, no big deal'. Just getting in the field and trying a few different places. That would be a good idea.

Bob wanted to go to the actual store to practice the interviews live. He wanted the participants' to "pretend like you want the job, fill out the application, talk to the manager." Bob suggested that the best actual way to prepare for getting a job was to actually try to get the job.

Mark. Mark was a young white man who was 25 years old. He was diagnosed with bipolar disorder. During manic episodes he felt like he needed to take on the world and in high school he often tried. These intense times often got him into lots of trouble for fighting and being disruptive in high school classes. He also engaged in a lot of isolative behaviors that he hoped the program would help him change. He was matched with two different mentors who went out of their way to foster a relationship with him but he did not connect with either one and chose not to continue the mentoring relationship. He rarely smiled and sort of kept to himself but consistently showed up and struggled to pay attention in class. He wore baggy clothes and always wore a baseball hat. He had a very involved family who made a large effort to keep him engaged in the program. His goal was to be a scientist but then he realized that was too involved for him so he decided that he just wanted a job and that any job would do. When asked if the career exploration was helpful Mark responded, "yes I wanted to become a scientist, but then I found out how hard it would be, so I just decided not to do that job now, maybe do it later on."

Mark confirmed that he wanted more direct and personal support finding jobs. This statement was consistent with themes that emerged about having hands-on and concrete activities that would enhance the participant's development and vocational goals. Mark stated, "the class should be more directly focused on helping people get jobs." Mark affirmed that he wanted lots of job development activities to take place like "phone calls to employers to set up accommodations." Mark also pointed out that the classes should be by what participants' want : "schools, jobs, volunteer". Mark stated people with "similar goals should be in together. People who want competitive jobs should not be mixed with people wanting to go back to school." Mark declared that he wanted to be in a class with people who had similar career objectives. These quotes speak directly to the fact that Mark, like many of his fellow participants, want to feel that they are in a learning environment that situates them in the appropriate context to learn concrete skills in a tangible way. Mark thought it was a waste of his time to be doing activities that were not related to his goals.

Although Mark did not reach any new milestones in terms of an internship, a new job or a going on to further schooling, Mark experienced a new level of readiness in which he was more open to participating in the world and interacting with others. It was a major accomplishment for Mark to have "gotten out of the house more. I wasn't bored all of the time, stuck in the house watching television." Mark did not want a mentor and was not interested in attending any of the social events. For most of the classes, Mark sat with his head on top of his hands which were folded over yet at certain points in the discussion, he would interject a comment that demonstrated that he was paying attention. Mark stated that he'd "finally gotten away from my illness, and I was

able to do more things with other people." Mark explained, "sometimes do things with other people, go to sport events, go supermarket shopping, basic little things." Mark was just beginning to find his way in the world. Through Jump Start he was actively testing out what he could tolerate and what he wanted to experience. Mark stated that he used Jump Start to learn how to "challenge myself" in a situation that was safe and comfortable.

Jim. Jim was a young white man of 24 years old. His extensive history of sexual and physical abuse has left him struggling with post-traumatic stress disorder, depression, anxiety disorder, and attention deficit hyperactive disorder. He loves people and enjoys being the center of attention. His intense need for immediate attention often causes him difficulties both in classes and in his ability to connect with people. It is difficult for him to be in the moment and focus on the present discussion. His attention is already focused elsewhere when it is his turn to talk. He often contributes in class out of turn. Jim has had periodic episodes of homelessness over the past few years. He has a terrible temper and his short fuse contributes to his homelessness. He wants to acquire further schooling toward his goal of being a chef but he has trouble focusing and concentrating for long periods of time.

Jim expressed his level of frustration with the program. Jim stated that he let his feet cast the vote in a sense saying I stopped showing up because I was not getting what I wanted out of the program. He stated the classes were repetitive and boring and that they were not connected concretely or specifically enough to his goals for him to put time, energy and effort into them. Jim stated that he did not want to sit and listen to his fellow participants practice. He wanted to be doing the actual activities that would lead

him to a paid position. When asked what worked for him about the Jump Start program and what didn't, Jim stated:

> See, because of my, maybe my lack of showing up, or because I haven't dedicated too much time. I've only showed up only you know, once or twice a week. Which was expected of me because the classes were only once or twice a week. But the reason I stopped showing up for classes was because they were getting boring. It was repetitive. Too much stuff that I have already known. Sitting around listening to practice, it just wasn't useful to me. That's the reason for me stopping classes, because they are not really helping me that much. But I also understand that the upcoming year, you guys really could help me get a job or get into school and I'm very interested in doing so, but you know, if it means I have to show up for a class to tell you to do so.

Jim continued, "I'd rather do it myself. Because I don't like something hanging over my head, have someone tell me I have to show up for a class in order for us to get me into college." Jim admitted here that he understood that it was a partnership situation in reaching his goals. Jim used the phrase, "in order for us to get me into college." He also grasped that that teamwork cannot take place when he does not show up to participate in the activities that would lead him toward his goal. In a way, Jim felt the program had the resources he wanted but he stated that he felt the program might "hold it over his head" if he worked with the program. Jim may have been experiencing a level of paranoia regarding the program and his connection to it. After being given the option of working one-on-one with a job developer, Jim's attendance or commitment to the program still was not consistent but he had numerous reasons for not being able to make the meetings he continually rescheduled. Jim had difficultly attending and participating in the program in a consistent way. Jim wanted to be situated in a learning situation that would explain all the steps along the way that would take him exactly where he wanted to go. Jim essentially stated that if the program did not want to work

with him on his own terms, he felt the program was not useful enough to him or worth the time, energy and investment for him.

Jennifer. Jennifer stated her frustration in wanting to learn at the appropriate level skill-pacing. Jennifer wanted to be matched at the appropriate skills level so she could be properly challenged and supported. Jennifer expressed that she felt that the classes were too slow and/or boring for her. Jennifer explained,

> The computer class was good. The beginning was review for me. I kind of knew a lot of that stuff. I stopped going because I knew too much of the stuff and I was getting a little bored. I wanted to go back when they started the things I didn't know and then I just didn't.

Jennifer stated that she liked that the class started out slow in the beginning which helped her to get acclimated to the class environment but she was disappointed that the class did not pick up speed after the initial stages to meet her level of skills so she explained that was part of the reason she dropped out.

Richard. In agreement with Jennifer, Richard also stated that he did not like the classes. He felt they were juvenile and not directly connected to finding a job, which was his goal for being in the program. When asked what he has learned about himself over the past year, Richard stated:

> Well, I'm learning how to do everything on my own, so right now I'd just really like someone to say, call this number and this person will give you a job if you're serious. I don't want to sit down and write what I'd like to do and not do on a piece of paper. I want to get the hell on the phone. I ain't got time to just sit around and talk about it. I just got to do it.

Theme Three: The Importance of Taking Positive Steps

Janet. Janet was a twenty-one year old Asian woman. She explained that she has known since early age that she was interested in engineering. She successfully entered an engineering program. Janet was diagnosed with bipolar disorder. She had trouble sitting and focusing for long periods of time. She never thought she could go back to school but she explained that she developed a new-found self-confidence. Janet expressed that her family has been very supportive of her schooling and the challenges related to her psychiatric disability.

Janet stated several times that the Jump Start program was a "good beginning stepping ground" and "mainly a positive step". Janet commented that it was not the career class, the staff or the social activities that made an impact on her vocational recovery, but it was her ability to interact with the supports in her life. Janet explained that she benefited not so much from the Center or the program itself. Janet viewed the center as a stepping stone to where she wanted to be. Janet shared, "Yeah, I like to get out in the morning and get it done. But it did give me good training for getting back into school, you know, beginning step ground, definitely good beginning stepping ground."

Betty. Betty was a twenty-two year old white woman. She was an artist who loved to paint. She was diagnosed with bipolar disorder. During the program, Betty was extremely curious about learning more information about her psychiatric disability and how to cope with it. She went to Massachusetts College of Art and had to drop out because she became too symptomatic. Betty frequently drew pictures in her notebooks in class. She hoped to return to painting one day but she stated that right now she needed to be focused on getting a job and maintaining her daily living skills. Betty

expressed her view of Jump Start as a place to develop her readiness. She explained that the center was a space for her to think about what she wanted to do next. When asked what she learned about herself over the past year, Betty stated:

> I think the whole experience of Jump Start was probably a stepping stone...forwards, not behind. It definitely was a positive thing, and not a negative thing...Especially, the mentoring, and like I said before, it's giving me something to do, like structure and having the communication with the students and the teachers. And coming to Boston. I know that I was uncomfortable every time I'd come down on the train and stuff, but it got me out of the house. And sometimes I would just stay in the house and be isolated if I didn't do the Jump Start program, and that's the truth.

Sam. Sam, short for Samantha was a young white woman. She was diagnosed with post-traumatic stress disorder. She had frequent bouts of anger followed by intense feelings of guilt and remorse. Sam was sexually abused by her uncle and wanted to escape the pain she feels anyway she can – through lashing out at others. She frequently lets her anger take over so she doesn't have to feel. She described her feelings as scary and out of control. She believed that anger was easier to express than to feel the extreme emotions of sadness and betrayal. Sam explained that she understood that expressing anger in inappropriate or destructive ways got her into trouble but she expressed that sometimes she can't stop herself. Sam remarked that when her behavior gets the best of her it interfered greatly with her ability to move forward. Sam shared that she desperately wanted to take a positive step in her recovery by changing her behavior but she was not sure how to do it. Sam explained:

> Well, I am the only one in charge of me and I'm the only one who can get me better. I need to work on my inner self. People tell me that if you want to change, why don't you change? In order for people to love you, you have to love yourself first. I hate myself. I can't wait for anyone else to do it for me. You're a grown adult; you should take care of yourself. I have to grow up. I have been here (in the hospital) since I was 8 years old and now I'm 21 years old. What happened to my life? I

> look at my brothers; they do normal things like go to the movies. Why can't I be normal again? That's it.

She wanted to be a surgeon but has not yet finished her GED. She had difficulties with focus and concentration since her abuse; but before it occurred she was a very successful student. She tried a GED program in the community but was unsuccessful. She struggled with the right dose of her medication and tries to cling to the idea that she still has a hopeful future after all she has been through. Sam said that she wanted desperately to take a concrete step in her recovery and was trying to be positive but it was becoming increasingly difficult for her. She admitted she occasionally got a case of the F***, it's when she felt like nothing was changing and she believed that nothing was ever going to go her way.

Nancy. Nancy was a 23-year-old young white woman with long brown hair and glasses. She was diagnosed with depression and post-traumatic stress disorder. She experienced long periods where she does not want to interact with anyone or do anything. Throughout most of the program all she wanted to do was stay in bed all day. She often had periods where she felt too depressed to do anything. She wanted to become a medical assistant. She recently completed her GED and was very proud of her accomplishment. She applied to a local college in their medical assistant program on her own, but the instability of her finances and her living situation prevented her from keeping up with her studies. When asked about her future career plans Nancy responded:

> Before I used to look at these jobs and think that I couldn't do them because they all required a high school diploma, or more. But now that I have that, that's one step. Most of them require a B.A. or this and that. I'll get there when I get there.

Nancy pointed to the fact that she had her high school diploma and that was "one step" closer to where she needed to be in her vocational plan. She dropped out after a few months but hopes to return to college next year.

Jim. Jim declared that he would rather be anywhere than where he was last year. Jim stated, similar to many other participants, that he wanted to be moving ahead in life. He expressed that he had a lot of career aspirations and that he really needed to work hard to achieve them. Jim was angry that he had not reached the goals that he set for himself, three or four years ago. Jim commented:

> I thought you were asking my opinion on my goals so you could help me get there. I'd rather have school and a job and rather not have made any friends here than to have tons of friends and still be in the same place I was in last year. Because I don't feel that I have accomplished what I set forth to do and I set goals three or four years ago, and to this day, only a few of them have been achieved. You know, I set goals in a month, in a year, in a day, and in two years, three years from then that I would have all this.

Jim stated, "and to this day, only a few of them have been achieved." Jim strongly stated that the reason for him being in the program was not to make friends, although he feels that he made some friends, which he stated in the quotes above. Jim pointed to the fact that he came to this program to meet his goals but that the program was not working with him in the way he wanted to achieve his career aspirations. Jim stated:

> Now here I am, it's going on four, maybe even five years that I've been out of school and nothing has changed. The only thing that has changed in my life is that I went from independent living to living with my grandfather, to living homeless, to living with friends, then back to living with my grandfather.

Jim expressed his level of sadness and frustration when he stated, "I haven't really accomplished much of anything, because you know, I don't really have someone I'm going to call my girlfriend, though I have friends that are girls. I don't have a car,

though I wanted one." Jim stated that he wanted to progress in life but he did not know how to work with the resources and supports that were in place in his life to work toward his desired outcomes.

Summary of Situated Learning

These participants' quotes stated that situated learning was essential to their growth and potential. Participants expressed their need to be actively participating in a setting that was an actual setting or in the closest proximity to it in order to develop the skills to be successful. Participants do not want to learn what they are supposed to know. The participants want to be exposed to the experiences and skills that would link them up with the educational and employment opportunities that they want.

Results of Research Question Two

Under the second research question: What were the participants experiences interacting with supports in their vocational development and recovery, the four critical themes that emerged were as follows: (T4) Many participants needed opportunities and places for safe transitions; (T5) Many participants respected the role of professional support in their lives; (T6) Many participants struggled with the role of family in their lives; (T7), Many participants welcomed the role of staff support in their lives; and (T8) Many participant's valued peer support in their lives. Under this section, the participant's interaction with supports took many forms. The participants' interaction with various types of support was examined as follows: places, professional, family support, peer, and staff. Participant's stated that these have all been critical in their

development and vocational recovery. These supports were present or absent in participant's lives in many different ways: through a psychiatric hospital, a participants home or work, a vocational program, a mentor, and/or the participants family.

Theme Four: Place Support

Missy. Missy was an eighteen-year-old young African-American woman. After several periods of homelessness, she resided in a Catholic run shelter for women. She really wanted to get her GED, but had a difficult time accepting that she had a significant learning disability. She was diagnosed with schizoaffective disorder. She was often loud and animated in her discussion with other participants and staff. She wanted immediate attention whenever she came into the center. She experienced delusions regarding pictures talking to her. She believed that Puff Daddy inhabited her body and made her treat her boyfriend poorly.

Missy experienced high levels of delusions related to her psychiatric disability, which made it difficult for her to distinguish fantasy from reality. Missy demonstrated a high level of self-esteem that she attributed to her involvement in the church, which was her "safe place" that allowed her to grow and change. Missy stated that she believed that she was haunted by a demon in the form of a dead singer's picture on her wall. Missy was so adamant that this had happened to her that she refused to say the singer's name out-loud for fear something might happen. Missy declared:

> There was a picture in my room, and it was a person who had been dead for many years. And when I lifted the picture up, everything started to go back to normal and I started saying wow! I don't know how a picture can be an evil picture. I can't say the person's name, he was a famous singer, and he was evil when he was alive. And he died and I never realized how evil he was and I had the picture on my wall for all these years. Now you

> know what was going on with me. So one day, I said 'this person's dead, why do I have a dead picture in my room. So I decided to get off of my bed, and I ripped the picture up. Just like 'leave me!' and it left. The feeling I had was powerful. I ripped up the picture. It's weird because the person was in the house with me all the time, and now that he's not there I get good sleep, because he saw everything I do. I looked at the picture and it looked evil!

Missy stated that it was the church that enabled her to have her life back. Missy elaborated,

> I am so happy that God made me realize that it was that picture in my room that was haunting me all these years. And I've had it in my room since 1997, up on the wall. Same place, on the wall. Until now, until 2003.

Missy said that the church was her supportive place to develop her sense of pride and self-esteem. Missy stated,

> the devil will take you if you're vulnerable and don't like yourself. But now he can't touch me because I'm stronger and I love myself and I do things for myself. He can't touch me because I got baptized in July and got a certificate for it and everything.

Missy said that it was the church that had enabled her to turn her life around. Missy remarked,

> I need to get back into church. I know I need to go back to church. I know I have a mental illness, but that can't stop me from living my life. People say I've got a mental illness, I can't work, but that's not me. The mental illness is just something that's there. It can't stop me from doing what I want to do with my life. It's always been there, but I can cope with it. But if I let if affect me, it slows me down. If I keep doing what I have to do, I can succeed in life. I realize that there is a cure for mental illness; it's just to cope with it. I know what the cure is; it's just to cope. They can't find no cure. Just to live your life. People say in 2004-2005 they are going to find a cure for mental illness, that's just stupid. My cure is just to cope with it and work with it and I know I have potential and I know I can do anything I want in my life if I just put my mind to it. I ask God everyday for wisdom, knowledge, and understanding and he gives it to me. And I just need to focus and don't let no one discourage me. I have to keep going everyday strong because all we have is one life to live.

The church and the women at the shelter gave her the support and guidance that she needed to make the changes she wanted to in her life. Missy stated that she can now distinguish between what things were productive parts of her life like the church and what parts of her life she needed to get rid of like the picture of the singer.

Wanda. Wanda was a 19-year-old white woman who had short dark hair and brown eyes. She lived in a group home south of Boston. She was diagnosed with social anxiety and schizophrenia. She struggled with attendance at the program because of the long commute. She eventually had to leave the program because of lots of difficult personal events and health issues in her family. Wanda commented on the importance of having a supportive place that would assist her in her job searching activities. Wanda stated:

> Yes, I had another kind of vocational program that I was going to that was called New Progress and it was an employment resource program. What they do is they help you find jobs stuff like that. I had gotten a job working at the Buck a Book Store. Then I started to get a tutor and stuff for my GED to work on that. It kept me positive.

So for Wanda, her vocational program called New Progress was part of her hope in her vocational recovery. Wanda said that going to the Jump Start program increased her ability and her "outlook on looking for jobs" and therefore impacted her readiness to change. Wanda stated that she "took some of the positive feedback" to continue her development and vocational recovery in another program. Wanda stated "It made me join stuff so I could learn about getting jobs and stuff like that." Wanda expressed that both Jump Start and New Progress were positive places where she obtained support and hope.

Betty. Betty stated that the classes provided her with the structure and security she needed to take the next step and connect to the outside world. Many participants' expressed this need to have a safe structured environment in which they could come to develop their skills and connect with others. Betty talked about the importance of having somewhere to go that was not filled with expectations but had a lot of opportunities to develop oneself depending on one's readiness. Betty stated that her readiness was not at a level where she had the capacity to take full advantage of all the opportunities but felt it was an important step for her that she made the effort to actually come to class as much as she was able. Betty stated, "Because I think that if I wasn't in that place, then the classes could have been a lot more helpful to me and I would have liked them more."

When asked what worked for her in the program and what didn't, Betty responded:

> I think to be honest, during the time when I was taking the classes, I was so on my depressed side, my mental illness, and I wasn't really motivated to even come to the classes even though I did, so I wasn't very motivated or encouraged to be in classes, and my mentality for being in the class and learning something new wasn't very optimistic. So, I didn't want to come in here and be negative about the classes and say they sucked, and that they didn't help. For what they were I think they helped in the aspect that where I was in my life, I had a place to come to that was familiar. It provided structure, which was really important. It got me out of Hopkinton. It got me to meet new people. So, there are a lot of positive aspects. I think that there should be some credit due to the teachers who taught the classes, who were patient and really sensitive. And really aware of what everyone was going through, with a lot of the students. But, I think they would be more aware with me if I let them, but I kind of closed myself off a lot of times. I don't think I let the students get to know me as well as Miranda, who was more open, more personal. I think it's really important that I mention where I am and where I was coming from and I'd go to credit the teachers and their efforts.

Ralph. Ralph stated that he connected his depression to a school-like setting like the Center. Ralph stated that he was trying to determine if the center was a supportive place for his vocational recovery. Ralph explained that he felt more stable at this point in his life but he expressed great concern about being that sick again. Ralph stated he was terrified of becoming sick like he was when he was in college. When asked what worked or didn't work for him about Jump Start, Ralph replied, "Yeah, I think like it's fine but I think it's like, it seems to be too much like school." When asked in what way that Jump Start reminded him of school, Ralph stated, "I don't know, it's not like I have to wake up early or set my alarm, but it's just like, I don't know, I'm kind of afraid that I don't want to get depressed here. I think school made me depressed." Ralph stated that he had mixed emotions about coming to the center. He was very conflicted because although he felt very isolated at home alone, he knew being at home would not cause him to have a relapse. On the other hand, he made some connections with other participants and his mentor and he did not want to lose the connection entirely so he was in a state of confusion about what this place meant for him. He was not sure how to make it more comfortable for him. He also wondered if making it more like his home would help. Ralph explained, "I guess just like, um, I've been kind of like, I don't know, pandering around. I think I'm trying to like, make this my house, and I don't really think. Now that I think of it, it sounds like a bad idea." Ralph was not sure if taking the risk to come to the center was worth chancing a relapse.

Nancy. Nancy talked about remaining connected to her old program and how she felt that they still cared about her when she visited. Nancy understood that her new

program was less hands-on because they were trying to increase her independent living skills but that was why she wanted to stay in touch with the old program.

> My old program, the one, I don't want to say the one I got kicked out of, the Place of Hope Program. I went to an after school program through them. I graduated from that. I still go there every once in a while and talk to them. I think I pretty much aged away from the Place of Hope Program. I moved on in my residential program and then got stuck in a different program. There's not a lot of staff in my program; they just pop in once in a while. They kind of keep their distance from you. It's different than a residential. But if I need someone to talk to, I go back to the old people, even though I'm not a part of the program anymore. But they say it's ok. I really don't talk to people in the new program much; mostly about if I paid my bills. I don't talk to them about being depressed. Some people just don't understand. The whole housing situation; they wanted you to show you can be independent and do it by yourself.

Nancy stated that the tangible resources at Jump Start were very important to her.

Nancy explained, "I like to work on the computer; I come here like on a daily basis."

Nancy also stated having positive places that she could come to was also very significant in her development and vocational recovery.

Theme Five: Professional Support

Sam. Sam stated that she also greatly values the professional staff involved in her life. She stated that she has been in and out of hospitals since she was eight years old and so this was a way of life for her. Sam liked the hospital she was in then versus the hospital she was in before. Sam stated that she likes her setting because there are lots of staff and doctors encouraging her to do well. Sam commented,

> Being here is better than that other psychiatric hospital. Everyone in this new hospital is supportive. There are lots of people on my treatment team. I can go to the cafeteria and I have cable. It's nice here. I love it, (pause) not love it, but I don't want to get too comfortable. In DBT, we do a lot of homework. The people here are ok (in the hospital) but some

> talk to themselves, you can't have a conversation with a whole group of people like we have now. So I talk to my therapist and tell things to her. But I find it easy to communicate with Dr. Killroy. Now one day I'm going to leave (She is referring to the hospital). They helped me a lot. I know that I have a lot of support. I need not to isolate.

She stated she was happy when the doctor came by and said that she was "doing good work" and to "keep doing what you are doing." Sam stated that she possessed the capabilities to be out of the hospital but due to her trauma history and her violent behavior patterns she stated that she relied heavily on the hospital staff, the doctors, her mentor and the staff at Jump Start to keep her focused and on track. Sam explained, "I have lots of encouragement. I also have Dr. Killroy (her psychiatrist) who says if I'm doing a good job then I can leave the hospital and go to a partial program. I know I have the skills." She pointed out that she also needed their support when she makes a mistake and reverts back to her negative behavior patterns to help her not give up and still try to make progress against her aggressive tendencies.

Wanda. Wanda shared that she felt that the importance of professional support to her recovery process. Wanted explained that she was in "a therapeutic situation with seeing an outside therapist and stuff like that. I'm working on recovery with my emotions and I'm working with her to be different." She remarked that she was working with a therapist on "different techniques and stuff" so that she "can deal with issues in my life more easier and stuff like that." She stated that through this "therapeutic situation" she has made important changes in her life that have made a real difference in the way she expresses emotions and communicates with people. Wanda shared, "I actually feel that I've had better communication skills." Wanda expressed that she increased her level of self-awareness in therapy. Wanda stated, "I talk about

how I'm feeling with people. I know how to see things from a point of view that people are explaining things to me. I think I do better now communicating how I feel to people rather than just holding it all in."

Erick. Erick was stating that it was not the classes, or his mentor who he had difficulty actually making the meetings he set up with her, or the social events that made a difference for him in the program. In terms of his interaction with supports, Erick talked about the importance of his psychiatrists who he valued because he stated "I just get to talk to him about my day to day problems and things I'm concerned with."

Ralph. Ralph had experienced a severe level of depression and paranoia. Ralph was having difficulty distinguishing reality from fantasy. Participants often had difficulty reconciling the role of medications in their lives. It was difficult for many participants to admit that they needed to see a psychologist or be on medication. In this quote, Ralph tried to minimize the impact of his psychologist and the medication on his life by stating that he started to drink coffee at the same time, which he pointed out could have also impacted his mood. Ralph explained:

> Yeah, I don't know. I guess I see my psychologist every two weeks. I see a separate psychologist for medications. I don't know, I guess they've been increasing. They've been starting to give me an antidepressant and I don't know, I guess there's like a noticeable difference. But I started drinking coffee at the exact same time.

Janet. When asked who made a big impact outside of the training program and the Jump Start program, or helped her get along with anything, Janet replied:

> My clinicians at the outpatient program and my therapists and psychiatrists. They've all been important. And working with my meds to keep me stable. The emotional support has been there tremendously. The respect issue is great. I guess I couldn't ask for a better treatment team.

Theme Six:Family Support

Steve. Steve was a twenty-three year old white man. He was diagnosed with bipolar disorder and attention deficit disorder. He enjoyed playing many different kinds of sports but his favorite was baseball. He knew all the statistics for his Red Sox in exacting detail. His family owned a restaurant and he has worked as a dishwasher for several years. At the start of the program, he desperately wanted to go to college but his family was nervous about him going because he often starts things and does not fully apply himself so he never finishes. After the end of the program, he informed the program that he started at Bunker Hill Community College with two classes and was still working his full time job as a dishwasher.

Steve stated that his family and other friends outside the program provided him with the social support that he needed. Therefore, Steve stated that he came to the program for help with his educational and career goals so he wanted to focus exclusively on activities connected to those things. When asked what about anyone at work or outside of Jump Start has been helpful, Steve responded, "My family most of all. They pushed me the hardest. My friends tried to help me a lot." When asked how does his friends and family help him, Steve responded:

> I have a way of doing stuff for a little while and then saying I don't like it. Somedays it was fun, but sometimes it was just to get attention. I just told my friends and parents that I wanted to drop it, but they wouldn't let me, they said it would pay off in the end. Like I'm going to school and getting my life on track, stuff like that. They don't want me to quit.

Betty. Betty remarked on her appreciation of being able to connect with her parents but also her contrasting desire to feel independent. Betty stated that she wanted a level of interdependence with her parents in which she felt both supported and

connected to them but also had a healthy level of autonomy from them. Betty stated that this was a precarious balance that she has not yet figured out how to skillfully negotiate. When asked about family support, Betty stated:

> In the past year I've gotten much closer with them because I've had to because I feel like I was isolating myself a lot with other people, so I've kind of connected myself with them in maybe some ways that they probably don't want me to because…Now, looking back at how I connected myself with my parents, now the next step for me is trying to get away from my parents, in a healthy way, by moving out of the house because I'm 25 years old and I shouldn't be living w/my parents the rest of my life.

Kara. Kara was a willowy 22 year old who dressed in hip hop clothing. She was diagnosed with bipolar and obsessive compulsive disorder. She suffered from anxiety and depressive symptoms that make it hard for her to leave the house. Kara had difficulty connecting with her mentor. After a few failed attempts to arrange a meeting, Kara gave up. Kara gets claustrophobic easily and has an extremely hard time on public transportation, which is one of the reasons that caused her to drop out of the program after only a few months. Her decision to leave the program was also influenced by the fact that she thought she was moving to the south to be with her extended family.

As a result of her depression, Kara spent a lot of her time sitting at home watching television. Kara expressed that her dad, although he doesn't fully understand the depression, has been supportive in his own way. Kara commented:

> Yeah, my dad he hasn't thrown me out yet. He wants me to get a job. He says 'I want you to do something with your life and not stay home watching television all day.' He's been cool. He's been very supportive about everything. Trying to help me deal with stuff.

Kara explained that her dog has been a great source of comfort and support in her life. Kara stressed that her dog, Muffy, has gotten her through some very lonely and sad times. Kara elaborated:

> The deaths of the people close to me kind of hit me hard. There's a few things in my life that are positive. Don't think I'm crazy, my dog. Believe it or not. When I was crying over my grandfather and my Uncle's death, Muffy would come in the room and lick my face and I would lay there and bury my face in her fur and she was very helpful because she lays with me and I feel safe with her. Even though she's only a little baset hound, I feel safe with her and everything. She's very positive in my life. Yeah, that's cool. Muffy is really helpful and I'm always home with her during the daytime. We're kind of more close than we were before because I'm always home. My Dad told me if I leave my house to go to the store, Muffy stands at the door and waits for me.

Muffy has been an important sense of hope and connection through the deaths of her loved ones. Kara stated that Muffy makes her "feel safe" because she was always there and provides a constant level of positive companionship. The dog's love was supportive and unwavering which was a crucial emotional support for Kara. Aside from her dog, and the support of her dad, Kara did not have a lot of other supports that she could depend on. When asked what could have helped her stay connected to the program, Kara responded, "and the fact that my family has moved to the boonies. So, good luck to me on that one. Pretty dark and quiet. I live in a suburban neighborhood." Kara tried to connect with a local "mental health center" once but it did not work out, and even though her "friend" encouraged her to "call again" she had not been able to mobilize the strength to call again.

Jim. Jim explained that he and his family do not exactly agree on what was important right now as priorities in his life. Jim wanted a girlfriend, a car, further schooling, and/or a job. Jim believed his family thought a girlfriend and a car were

unnecessary distractions to what they believed were his main objectives. In contrast, Jim viewed a girlfriend and a car as crucial necessities in his life. As a result of this disconnect, Jim often experienced tension with his grandfather and would not go home for days or even weeks at a time. Jim explained:

> I don't really have someone to call my girlfriend, though I have friends that are girls. I don't have a car, though I want one. My friend wants to sell me his car for $400.00 but my family thinks that is a big mistake. Of course, anything that involves me getting something to complicate my life a little bit more, my family does not think is a good idea. I can't have a girlfriend. The only thing that they want me to have that would complicate my life a little bit more is a job or school and they don't mind me having that because it complicates my life in a good way, but a girlfriend or a car they really don't think is a necessity.

Theme Seven: Staff Support

William. William was a young Cape Verdian man who was still in high school. He wanted to be a record producer. He said he really enjoyed the social events, particularly the bowling and the pool. He did extremely well in high school and does not admit to having a psychiatric disability. He was, however, diagnosed with schizophrenia. He loves connecting and interacting with people, particularly around music or poetry. He did not want a mentor but he seemed to really engage and enjoy the support of the staff in the career development classes and exploration of his career interests. William stated that the staff support was an important part of his experience at Jump Start. William continued, "Debbie (instructor) and Kim (Co-manager of Jump Start/instructor) of course. The other one would be Lori (instructor)." One of the main factors that William expressed was that the staff listened to him and also explained things to him in full detail. William explained:

> They always listened. They gave me good advice. They did a good job teaching the class. They did a good job about going into detail. Not leaving too much uncovered. Debbie was out a lot, a lot more than I wanted her to be. But I was out a lot too, so I can't talk. Pretty much all the staff that I have encountered have been sufficient during my stay at Jump Start.

William shared that Lori (instructor) "hooked me up with a record producer friend of hers who used to live in New York who's not into hip hop but he's into music." William shared that he was excited about the informational interview at a recording studio. William expressed that he really loved the experience of actually talking to and exchanging ideas with an individual in the business. William explained that they had:

> An informational interview, where he gave me some very, very good advice. About how there is more to music than being just a record producer. You can do things behind the scenes too. That was basically what that conversation was about. He's in another field of music so he didn't help me get anywhere but he helped me as far as things I needed to know.

William felt like his vocational goals were valued and respected when the instructor, Lori, set up an informational interview with a record producer. He stated that the man gave him good advice and pointed him in a positive direction on his career path.

Cyril. Cyril was a 21-year-old Haitian-American man. He came to this country when he was 12 years old. He had a slender but muscular build and wore his hair in cornrows. He loved basketball and rap music. He idolized the famous rapper named Fifty Cent. Cyril was in denial of having a psychiatric disability even though he has been diagnosed with schizophrenia and actively experienced delusions. He had been completely noncompliant with any medication and has consequently not been able to leave the psychiatric hospital. He often used marijuana to self-medicate. He had significant learning disabilities compounded by the fact that English was his second

language. He dropped out of school in the ninth grade and has never really felt at home in this country. He has been trying to obtain his GED for years but has not been able to keep up in a community GED setting largely due to his ongoing symptoms. He has been trying to stay connected to this program but never could fully engage because his symptoms were so severe that they hampered his everyday functioning like getting out of bed and getting to the program.

Cyril was seeking a personal connection with someone who could chart his progress on the GED and encourage him in a very connected and personal way. Cyril expressed his need to be heard and understood for who he was. He not only wanted help obtaining a GED but he wanted help in understanding himself and his mental health. He wanted a supportive and personal situated learning context that was tailored to meet this specific learning style and goals. Cyril explained:

> I want to work one-on-one with someone. I want someone to work with me; like writing a paper every time, maybe about my mental health. I feel way behind. I'm feeling trapped. I can't think. I can't focus. I see this place as a place of opportunity but I don't have the same ideas as somebody else. I don't have any idea about what's happening to me.

In this quote, Cyril talked about writing a paper "about my mental health" because he was struggling to understand what his diagnosis means for him in relation to the rest of his life. When asked what he learned about himself over the past year, Cyril responded, "I learned I was very kind. I learned I wanted to be part of the community and work on myself. I am trying to help myself and work to help others understand me." He was frustrated about not being able to think or focus and he was desperately seeking a better way of doing things in his life. Cyril explained "I like being in class with people; just learning. I want to learn something that can help me in the long run. Right now, I'm

just living. I regret most of the things I've done." Because of his psychosis it was difficult for Cyril to stay involved in the program for any consistent length of time. Cyril desperately wanted to be part of the program because he hated the hospital he was at and he felt comfortable and safe in Jump Start. When asked what has made an impact on him in the last year Cyril responded, "nothing has made an impact. I moved from the hospital, that hospital wasted my time. I'm wasting money, taking medications. I feel numb. I want to try and notice and function." During the Jump Start program, Cyril remarked to a staff member that he actually felt happy and it was the first time in he didn't know how long that he had felt happy. Cyril wanted staff support most of all because it was accessible and because the staff took the time to try to help him learn and understand his issues.

Miranda. Miranda developed a strong connection to the staff. Miranda connected to the staff and her mentor much more easily than to her peers. When asked what relationships had made an impact on her over the past year, Miranda remarked, "all the staff, all the participants, mostly the relationships with the staff. I remember when I first came; it felt kind of different for me. Then I got to know some people." This is probably due to the fact that she spent most of her life in and out of psychiatric hospitals and most of her interactions were with hospital staff, psychologists and psychiatrists. Miranda was not exposed to the everyday activities of young adults her age. Miranda was not actively engaged in social situated learning activities that were developmentally appropriate for her age, like high school classes, after school sports or activities. Since Miranda was not part of the situated learning experiences of other teenagers, she has a lot of difficulty relating to her peers.

Richard. Richard was a twenty-three year old Asian American. He lives at home now with his parents. He goes back and forth between wanting everything and wanting nothing from the program, his friends and the world. He has been in and out of psychiatric hospitals since he was seven years old and has an extensive trauma history. He was diagnosed with bipolar disorder and tourettes syndrome. He worked hard to control his ticks throughout the day so that no one noticed them. He explained that he looked forward to going home at night so he no longer has to work so hard to control his body movements. He had periods of depression where he couldn't get out of bed for weeks before 2:00pm. Then, he experienced intense periods of elation where he seeks to take on the world single-handedly. He stopped taking his medications and uses alcohol and marijuana to self-medicate. He had very strong narcissistic tendencies. Richard had a deep sense of self-hatred, which he projected onto most people around him. He had a history of cutting and was frequently tempted to hurt himself when he wanted to connect to his body to feel physical pain. Richard, however, did make a strong connection with the co-manager of the program, Sasha. Richard frequently expressed his disgust with everything about the program to his other service providers, to other Jump Start staff, but he continued to meet and check in with this one staff member on a regular basis. He stated that Sasha was someone who he cared about, trusted and valued her opinion even when he disagreed with it or chose not to follow her guidance. Richard stated:

> What I've gotten out of this program had nothing to do with the classes. Derek (a Tai Chi instructor) was really down, I really liked him. He seemed genuine. And then there is you (Co-manager of Jump Start, Sasha). I really didn't trust or care about anybody else.

Richard often admitted that he understood what she was saying, why she was saying it and what elements of it might have value for him at a different point in his life. In contrast to almost everyone else he came in contact with, he was angry, rude and intolerant of anything they talked to him about.

Erick. According to Erick, the personal connection that he established with one of the staff was also important to his development and vocational recovery. Erick stated, "Donna (an instructor and job developer) made me a resume. That was really helpful." A job developer named Jaffray was someone else who he established a personal and trusting relationship. Jaffray gave him specific and personalized guidance on how to pursue internships and jobs. She assisted him by making a few phone calls and searching for jobs with him. Jaffray and Erick would often sit in the computer lab and work one-on-one following up on things Erick stated he was interested in. Erick stated this was far more helpful than the classes because these were concrete hands-on activities that were directly related to his life and what he wanted. Erick explained that Jaffray "talked to me about the potential for me to get internships and just in general I like talking to her. She's an artist and I admired her. " Erick stated that Jaffray was "very, very helpful" and a "good influence, maybe a little more positive about things."

Nancy. Nancy stated that staff support was also important to her. Nancy remarked, "I talk to you (the interviewer, Kim) and Donna (instructor and job developer). I talk to Jaffray (instructor and job developer) a lot." Nancy continued, "I needed to do a cover letter. Jaffray (instructor and job developer) said she'd help me. I want to apply at a hospital. Not that I'm going to try to be a surgeon or anything, but there's a lot I can do." Nancy valued the one-on-one support she received from the

instructor, Jaffray, as well. She enjoyed meeting with Jaffray and working on her job search together. Nancy commented here on the importance of the staff to help her with the tangible products such as cover letters that she needed to conduct an effective job search.

Frank. Frank expressed that he valued Sasha (instructor) and Stacey's (GED instructor) help in the GED classes because they did not do the work for him but they modeled what he needed to be doing. Frank explained, "They read real slow and helped me understand it. I read it myself slowly." Then they gave him the opportunity to try it for himself while they helped him work through the GED problems. Frank felt understood and supported in the GED class because the instructors taught in accordance with his skill level. They were there to help him improve his reading skills and comprehension so that he could do better on the problems.

Individual Quotes on Staff Support

Tom agreed with Cyril and Miranda about the importance of staff support. Tom stated that he valued the support that the job developer Donna gave to him. Tom explained, "I formed a relationship with Donna (instructor and job developer). Donna really cared about me and she thinks a lot of me." David also valued his relationship with the staff when he commented, "Lori (instructor). She helped me get this internship that I'm starting tomorrow for dealing with Architecture and she helped me with my resume." The participants stated that they felt supported by the staff through talking with them and working with them on her job search. When asked what relationships made an impact on her over the last year, Sam responded:

> You (the co-project manager Kim) made a big impact on me and that helped me. Donna (an instructor and job developer) made an impact. Lori (an instructor) made an impact. The whole staff talked to everybody, which was good. You all helped me in different ways and I really appreciate that.

Theme Eight: Peer Support

Debbie. Debbie was an Asian young woman who was 22 years old. She has short wavy black hair and small brown eyes. She lived with her parents and wants to go back to college but was scared she might get sick again. She was diagnosed with schizoaffective disorder. She frequently experienced delusions but learned to distinguish which ones were harmful and which ones have become just harmless diversions. She often saw flowers growing in places that it would not be possible for them to grow. During periods of heightened stress, she sometimes experienced suicidal and homicidal thoughts. She loved to write and is always trying to capture her thoughts in the form of a poem or a rap lyric. Debbie stated that she liked the concrete skills of "writing a resume". Debbie also stated that she liked the hands-on activities of "doing collages".

Yet the support that Debbie stated she was really interested in and found valuable was how to interact in a group setting of her peers. She stated she was learning how to discriminate between how to act in one setting versus another setting. Debbie explained she was learning, "how to be in one setting and be one person and be in another setting and be another person. Sort of like different sides when you are supposed to show them." For example, being in the kitchen of Jump Start with a peer was different from being in a classroom or meeting one-on-one with a staff. She was

struggling with the different levels that one shares with individuals versus a group and in class versus one-on-one. Debbie stated that it was the "connectedness" that worked for her in the program. Debbie stated that she liked learning "how to make collages" because "they were a way to express yourself and your opinions and at the same time it is not threatening." Debbie commented that the concreteness of the collages allowed her to share parts of herself with her peers in a way that she felt comfortable. It was a safe way to connect with her peers in a genuine but non-intrusive way.

Ralph. Ralph was a young white man who was 23 years old. He was diagnosed with bipolar disorder. He was psychotic during most of his time at the program. He rocked back and forth slightly both while seated in a chair and standing up. He heard voices and frequently drew elaborate pictures on his notebook the whole time during class. He said drawing helped him to be more in the moment and be less distracted from the voices. He loved music, especially the Grateful Dead. He also often drew pictures of the bands logos and portraits on his notebooks. Ralph chose to do his PowerPoint presentation on the band in computer class. Ralph explained that he also uses music as an isolating behavior and would sit and listen to music for hours on end alone in his room to avoid interacting with anyone. He experienced great difficulty concentrating as a result of his medication changes. He went to Cornell University for a year but he had to drop out because he had his first psychotic break.

Ralph stated that many of his friends had gone off to college so he has very few people left in his life with whom he related well. Ralph was desperately looking for ways to connect to others but was still fearful of things that he thought might trigger his more severe symptoms again. Ralph stated that he enjoyed the Jump Start activity at

Boston Billiards. Ralph explained, "I like playing pool with my friends. It feels more comfortable." He enjoyed connecting to other participants but was not sure how to sustain friendships when they had difficulties. When friendships or plans did not turn out the way he had hoped, Ralph placed a tremendous amount of guilt and blame on himself, which unfortunately increased his anxiety and depression. Ralph explained:

> Yeah, I don't know, the first week or so I kind of made friends with Jim. I don't know, we hung out a while together, he brought his Play Station over and he also dropped his hedgehogs off with my parents. They didn't have a home, and so like, let's see, I completely forgot what I was trying to say. So, what happened, oh, so I guess like he's going to get them some other time. I really haven't seen him lately because he didn't really have a house for a while and uh, he, I don't know he seems like he's been avoiding me lately but … uh, I don't know.

Alison. Alison talked about the level of personal support and connection she received from her peers at the center. Alison explained that she was able to connect with them in a way she has not been able to with other friends because, like the mentors, her peers possess a level of understanding from a place of experience not just of knowledge. Alison noted that she really appreciates the fact that she expanded "her circle of friends" with an "exceptional group of friends because we have a connection that is unique that most people don't understand." Alison stated the participants and I "can at least share our feelings about how we feel about this illness. How it affects our lives. It is nice to be able to encourage one another and that things are OK." Alison shared:

> I've definitely gotten friendships out of this program. I have really enjoyed being able to connect with people. I thought it might be temporary just to share you know, a similar mental illness and to just be a support to each other. You know, to not feel that we are alone or different.

Alison confirmed here that her peers supported her in the belief that "things will improve in spite of this illness." Alison continued, it has been nice to "go to the movies, out to dinner" with the friends I have made through the program. Alison stated that peer supports were a critical part of her development and vocational recovery because her friends can relate to her and provide her hope in real and satisfying ways.

Jennifer. Jennifer remarked that her new boyfriend was an important support to "keep me on track." Jennifer explained that that means he keeps her "doing the things that I'm supposed to do like come to my job." Although Jennifer stated that she enjoyed coming to work and really likes the people she works with, sometimes she said she needed her boyfriend to remind her "what I need to be doing because I do like the people a lot and I do enjoy my job."

Individual Quotes on Peer Supports

In reaction to a question on the Interpersonal Support Evaluation List (ISEL) about friends, Miranda responded "but what if I don't have any?" Miranda expressed that she did not dare talk with the peers that she hangs out with about things that are important to her, such as her desire for a job or her private thoughts. Miranda agreed with Alison's perspective on the importance of developing peer supports. When asked about spending time with other participants, Miranda replied:

> We went to a restaurant, went shopping, and just hung out. I liked the activities we had with the whole Jump Start. It was fun getting to know them, and joking around. It was really cool. It helped me feel more belonging. They could relate to my struggling, but on different levels.

Tom agreed with Miranda when he stated that he too valued the friendships he formed with other students. Tom stated, "I formed a relationship with Jim and Ralph;

and with Suzy, from the other program; she's a good friend too. That's about it." Amanda, like Ralph, had trouble reaching out to other participants. Amanda shared, "I tend to have problems with social skills, especially when I reach out. I personally tend to isolate myself and didn't expect myself to go outside my circle. I have certain kinds of tendencies." Jim explained his interaction with other participants' and how he related to his peers in the program. Jim talked about having positive and negative relationships with participants. Jim stated, "sure, me and students, we talk. Me and Ralph, we talk. Even Miranda talks to me. I talk to Ralph every time I get a chance. I have his number on my cell phone. I'm probably closer to him than any of the other students." Jim explained, "students' do different things. Some are cool as sh**, and some I just don't talk to." Jim was stating that he really like some participants' and then did not really bother with others. Jim stated, "In fact, there is only one person here who I really don't like and I don't even know his name."

Betty, like Ralph, also stated that it was difficult for her to connect with her peers because of her psychiatric disability and her changing levels of medication. Betty stated,

> I think that one of the things that made it difficult for me to be totally comfortable coming here was a lot of my paranoia. Sometimes I would obsess on what the teacher said or analyze what the teacher thought of me or what the other students said in class.

Betty explained that sometimes she had "irrational thoughts" which made it difficult to connect with her peers.

Cyril also expressed that he really wanted to connect with his peers. Cyril shared, "I like the GED classes. I like being around people." Yet, Cyril found it very difficult to relate to his peers because of his psychiatric disability. Cyril explained, "It

was difficult to communicate when I couldn't understand the words coming out of people's mouths. I like getting along with people, and like the computers." Cyril stated that he made a connection with one other participant in the class but he admitted that he "forgot his name." Then Cyril described the participant, "he was about 17 or 18 and he had a job. I feel very alone. I have friends but I can't get through to them." Cyril was frustrated because he could not connect to the other participants in any meaningful ways.

Steve commented on how he liked the other participants' but he did not really form any close or lasting relationships with other participants. Steve stated, "I've formed many relationships in Jump Start, but not outside Jump Start. When I come here, I like to talk to them about sports and stuff, but I don't like to hang out, not buddy-buddy." Steve stated that he would exchange pleasant conversation or information but not talk about anything significant. Steve explained, "We just hang out here and talk about what we did over the weekend. But we don't ask 'what are you doing Friday'? But I've made some good relationships with a couple of people here. That was really good." Steve said his life outside of Jump Start was really busy and he did not have a lot of time to do activities with Jump Start or the other participants.

William stated that he enjoyed connecting with other participants at the program. William stated that he really liked "the bowling" night at the program. But William agreed with Steve that he wasn't really looking to interact with other participants outside the program. William remarked, "Steve was the one I would say I probably got to know the most." William continued, Steve had "an appreciation for rap.

I think we connected the most because we had a lot of commonality as far as what we liked. We both like basketball."

In contrast to Steve who did not make a conscious effort to make friends at Jump Start, Richard deliberately chose not to associate with any other participants. Unlike Cyril and Betty who tried to connect to participants but were unsuccessful, Richard had no desire to connect or relate to his peers in Jump Start. Richard remarked, "I have made no relations of value with other Jump Start folks. Most of the people here are in worse shape than me and I hang out with people who are better than me."

Results of Research Question Three

Under the third research question: What were the participants and mentors experiences with the mentoring relationship in their vocational development and recovery, the critical theme that emerged was the desire for peer role models and support in the form of a mentor. This section dealt with the importance of mentor support in the lives of the participants. It delved into the need of participants to have the opportunity to make a direct and personal connection with someone who understands or can personally relate to what they are experiencing because they have been through similar psychiatric challenges. The common ideas the participants' spoke about in the quotes below were: having someone who was not a parent, service provider or part of the system who was there for them when they need someone to listen; was there without judgment or expectations; who was just there for them when they need someone. Some participants wanted a friend, others wanted a career counselor, others just wanted someone to do stuff with, like go to the mall or the gym. Sometimes it was

emotional support, other times it was information or advice they were seeking. Mostly these participants were just looking for support. They were seeking a safe way to practice being in the world that was okay for them. In the second part of this section, the mentors' perspective on the mentoring relationship is also examined.

Theme Nine: Mentor Support

Amanda. Amanda expresses that she thrived on the one-on-one support she received from her mentor, Kate. Kate and she worked on things like time management and breaking down assignments into manageable steps. Amanda stated that Kate actually mentored her in a way tailored to her situated learning style. Amanda stated that she felt totally connected to her mentor from the start of the program. Amanda explained "I realized that in (our) the first meeting. Being with each other and talking with each other leads to getting involved in wonderful conversations about everything under the sun." Kate helped in the actual situations that Amanda was studying and working in to be more effective. Amanda stated that Kate helped her with her work at Berklee; and she also helped her in her everyday life with organization-both practical and conceptual skills. Amanda explained that Kate helped with "essays from Berklee College of Music and trying to get it organized. She was very helpful with organizing my thoughts." When asked what did she think has been most helpful or valuable about her mentor, Amanda responded:

> These days we set it up so that my mentor, Kate, would call me every morning about 9:00 and we would talk about how yesterday went. We try to come up with things for me to do. I think I hit roadblocks during the day if something unexpected happens or takes longer than I thought it would. It's just something that I needed help with in the past. She helps

> with that phase. Her schedule is much more crowded up; I have a lot of freedom. I can't just call her up anytime.

Amanda stated, "everything with her has been helpful, there's not any one thing." Amanda declared the program "matched me perfectly." Overall, Amanda felt very supported by Kate in the exact ways that she wanted and needed to be supported. Kate's thoughts about her mentoring relationship with Amanda will be explained in the mentoring section of this chapter.

Miranda. Miranda really enjoyed interacting with her mentor, Lily. Miranda stated that Lily has "been a really big help in my life. We have a positive relationship." Miranda loved the one-on-one attention in the mentoring relationship. Miranda greatly admired her mentor and wanted to spend as much time with her as possible. Miranda expressed that, "The support, it's good to have someone who's been through something and is out there making it. It gives you motivation. It's also good to have a relationship with someone." When asked what kind of things did she do with her mentor, Miranda responded,

> We went to the movies, worked on homework that I had to do, looking up information, just hanging out, you know? Driving around, and going hiking. We went hiking and that was fun. It was really cool. One time we baked Christmas cookies and made homemade cards and stuff. We talk and it's just really good to do different things.

Miranda did not care what activities that they did together; as long as she was not in the hospital, she was happy. Miranda greatly enjoyed the company and being able to go places and try different things with a caring and supportive person.

Janet. Shortly after coming to program, Janet was connected to a mentor that was in her desired career field, engineering. Janet and her mentor, Stacey, had a lot in common. Stacey introduced Janet to an engineering program into which she was later

accepted. After meeting Stacey and being connected to the engineering program, Janet did not come to classes, meet with staff or attend social events but she did stay closely connected with her mentor and her other supports. When asked about the relationships she had developed over the past year, Janet responded:

> I met a lot of very accomplished different people through here, mainly my mentor, Stacey. She introduced me to the engineering program and she's still there. She let's me rely on her if I need help and I guess if I hadn't come here then I wouldn't have found out about the engineering program. I guess this started my schooling mainly in a positive step. Out of the main part of the Jump Start program (she is referring to the Jump Start classes) and into a positive future.

Janet stated that the Jump Start program connected her to supports, her mentor in particular that could effectively support her in her environment of choice, an engineering program. Janet stated that she used her supports to effectively transition back into school, which was the environment that would allow her to reach her vocational goal. Janet realized that her ability to utilize the supports and opportunities that she was given was a terrific skill. These skills set the stage for her to recognize and develop her own inner strengths and capabilities. Janet went on to say, "I learned that I can do the work and I learned more about me on a personal level. I can do more than I gave myself credit for. Janet went on to say, "I learned I can do it. I'm doing it." Through this statement, Janet was noting that she was in her desired environment and being effective, and that her mentor was a significant part of her vocational recovery because she helped to start the process as well as support her throughout.

Rudy. Rudy described her mentoring relationship with Claire as very valuable because she was "an activity buddy", someone to go out and do things with and share activities. Rudy stated she had not been in school for a while and "lost touch with many

of [my] friends and it was nice to have someone to do things with." Therefore, Rudy felt that Claire helped her get out more into the real world and practice her social skills in a safer more transitional way so she could build back up her confidence and competence in those areas. Rudy stated:

> I've developed a good relationship with my mentor, like friends. We do activities together. We went to different places together. We went to Kennybunkport, Maine together. I don't feel like I shared a lot with her. We were more like activity buddies together. We went to Jillian's (a pool hall) and we went to the mall and we went shopping around Boston and that type of thing.

Rudy felt that her internship and her mentor helped her redevelop the skills and the confidence in a hands-on way that helped her go back to her truly desired setting, a college setting, where she could apply her newly enhanced skills. Claire will explain her thoughts on her mentoring relationship with Rudy in the mentoring section of this chapter.

David. David, like many participants', especially the males, liked physically connecting with his mentor over activities and sports. David stated that what he liked best about the mentoring relationship was "doing stuff." David described playing pool, basketball, softball and going to the gym as activities he really enjoyed doing with his mentor. David stated that going to the Fenway for a tour was also a cool activity. Doing activities together was actually much more preferable than getting together to talk. David explained:

> Al, my mentor, we did a lot of stuff. Maybe every couple times a month we'd do something. Like went to the Fenway. Got a tour of the Fenway. It was really fun. Like we saw the players' locker room. I had never been in the players' locker room. Then he went over my house once and we played basketball at a local gym. We went to the Boston Billiards with the

> program too. That was probably the biggest thing that we did. I stayed in contact with him and had a pretty good relationship with him. I've never had a mentor before I came here.

Most participants, especially the male participants, liked having a set agenda or having something to do. David liked having an "activity buddy" to use the phrase that Rudy coined in her quotes. David stated that his mentor was not central to his vocational recovery but was someone he valued to hang out and do things with. David explained, "we just basically hung out" together. Many of the participants' had difficulty making the effort to stay connected but found it very valuable if they could maintain their connection. David stated, "it was just a little hard to stay in contact sometimes. You had to call sometimes, and he was busy. It was different kind of relationship. A little harder. It was fun to do stuff. Kind of. Yeah." Al's point of view on his mentoring relationship with David will be stated in the mentoring section of this chapter.

Nancy. Nancy valued her mentor relationship with her mentor, Alice. Nancy stated that she enjoyed doing activities with her mentor. When asked what she and her mentor did together Nancy responded:

> We talked about a lot of stuff. We went to a bookstore, a museum. Mostly we just talk. We talk about my living situation. I like to go look at her cats. I saw her work. She's giving me ideas about what classes I can take for writing and stuff. We are both the same kind of people. She pretty much understands the whole mental health thing.

Nancy expressed that she appreciated that Alice had experienced similar things as her and understood where Nancy wanted to go. Nancy remarked that her relationship with Alice was "kind of like the whole 'been there, done that'." Nancy explained that her life was made easier because of Alice's guidance; she stated "It's not as complicated, you know the job search and stuff."

Debbie. Debbie expressed that she had a strong relationship with her mentor, Claire. Debbie shared, "we went to lunch, and then we went to Fanueil Hall. We took some walks." Debbie explained that Claire was very helpful because they "talked about papers for school." Debbie remarked that she valued the fact that Claire "had a background in college. She knew how to write." When Debbie was asked how else her mentor had been helpful, she replied, "just to be there." Debbie felt that it was important to have someone who was willing to be there and listen. Debbie valued the fact that her mentor was there to do things with and to talk about things that were important to her in her life.

Betty. Betty greatly valued her relationship with her mentor Alice. Betty expressed her satisfaction and comfort knowing that the mentors' understood first hand the pressures and challenges of having a psychiatric disability. Betty talked about how she felt it connected her to her mentor in a unique and meaningful way. Betty explained:

> I've gotten to know her very closely in the small amount of time that I've known her. And we've not only done multiple activities together, but we've really grown close. I feel very connected to her. Just the other day I was with her and she said that she thinks of me as one of her friends. And, it's nice to know that despite an age difference, we can have a connection.

Betty shared that she felt it was significant that she and Alice shared the same severe psychiatric disability. Betty explained "and also the connection that we're both bipolar. I've been able to ask her a lot of questions about living with a mental illness that I haven't been able to ask other people. My friends have no clue or interest or any desire to know about it." Betty expressed how much of an impact her mentor, Alice, made on her life. Betty valued the time and activities they spent together. Betty stated:

> We'd talk. We'd do walks. I just went to her apartment and hung out. She showed me her artwork and cooked me an omelet. We've gone to the North Shore and walked around all the art galleries. She's come to my neck of the woods and I showed her the beach. So we've done this and that.

Betty felt that she and Alice were matched very well because that had similar artistic interest. Betty shared:

> My mentor had made an impact on my life, even if I only see her once a week or once every other week. It still makes a difference because it's important to make connections and feel connected, and know that there's someone out there that I can talk to because at the time I didn't have a therapist, and so, I hate the word used, but I could use Alice as my therapist. She was my mentor, so I think she kind of filled that role. So, that was our relationship. I think that's really the only significant one other than the one with my parents.

Betty declared that she was thrilled that her mentor and she shared the same interest, which was being an artist. Betty was surprised that just because she requested that her mentor be someone interested in art that it was able to happen.

> When I asked for a mentor, I wrote I want someone who was into art. Yeah, she's a great artist. She's great, very talented. I went to art school for a year and a half and then I dropped out because my illness was kind of getting in the way. So, now I do artwork every once in a while, but really haven't been that motivated.

Betty emphasized that her relationship with her mentor, Alice, really made a significant impact on her development and vocational recovery. Betty appreciated that they had so many common interests and enjoyed the same activities.

Bob. Although Bob and his mentor, Carl, shared the same career interests, Bob stated it was more important for him to connect with his mentor on a personal level. Bob expressed that he enjoyed just talking and sharing stories that were important to one another. Bob shared that "Carl and I had a lot to talk about because he's in the educational field himself. We had a lot in common and we could talk over dinner about

my classes and stuff." Bob enjoyed hearing "war stories" about teaching and talking to Carl about the classes he was talking. Bob explained that Carl was not really a career mentor but "just someone to discuss common interests and career interests." Bob also remarked that he enjoyed going out to play pool and to a ball game with Carl. Bob commented that it was fun to have someone to go out and hang out with, who had been there and done that.

Ralph. Ralph felt really connected with his mentor, Gary, but was frequently concerned that he is not doing the right thing or disappointing him. Upon entering the program, Ralph was very isolated and was experiencing a severe level of depression. Ralph stated in his initial interview he just wanted more "human contact." Ralph has stated that he liked meeting with his mentor but lately he feels that he was letting his mentor down because he was not able to follow through on some of the career development worksheets that Gary had given him. Ralph expressed:

> Yeah, I think Gary started to notice that I've been kind of slacking off with life. Gary gave me some worksheets to fill out and some papers to read over and he just like will laugh when I kind of told him I forgot to do it. He didn't like get angry or anything. I guess I wasn't being too responsible. So I don't know, maybe next time I'll try to start working again but I notice the same thing in my meditation class. It seems like I'd rather leave, go outside for a cigarette, sit in the lounge for a minute, drink coffee, and then go to the class. I guess I had trouble focusing and that was the point.

Ralph expressed that he felt a lot of guilt when he was not motivated to work or could not focus on his vocational goals, especially with his mentor. Ralph explained:

> Yeah. I think my mentor, Gary, has a cold lately so I haven't been seeing him all week. He had to leave last week, then he cancelled today's appointment, but other than that it's just like I haven't been as motivated to do stuff, like watch movies I wanted to see, read books again, and stuff like that. I guess he might be getting bored, because I'm not contributing as much to my progress.

Ralph admired Gary and enjoyed connecting to someone other than his parents but he was always concerned about letting him down by not meeting his expectations.

Sam. Sam stated first that she greatly values her relationship with her mentor, Mary. Sam talked to Mary almost daily and relied on her for positive encouragement and feedback about her progress. Sam explained, "my mentor, Mary, has made a good impact. I talked to her everyday you know. Well, Mary encouraged me to do better. She's helping me with the WRAP (Wellness Recovery Action Plan), and was teaching me the GED. Sam continued, "she just gave me a lot of support and when I have a problem or I'm just sad, I call her and she just listens to me and she gives suggestions. It's very helpful." Sam commented that she really valued being able to connect and share things about her everyday life with her mentor. Sam greatly respected Mary and enjoyed spending time with her.

Steve. Steve described how he met his first mentor and he stated that he "didn't click with him right away". Then, Steve met his new mentor, Lewis, and he liked him right away. Steve stated that he liked doing activities with his mentor, like going to the gym and playing basketball. Steve said "and things were going good." Steve, like David, really enjoyed "doing stuff" with his mentor instead of just sitting and talking. Steve stated:

> We played basketball, talked about jobs, what he did for a living, what I did for a living. Like where I wanted to be in the next year or two and how he could help me. He said he had connections at a school where he used to work. He said he could help me with that.

Steve said he understood at first when his mentor abruptly stopped calling because Lewis had a family emergency. Yet Steve was disappointed that Lewis never made a really serious effort to get back in touch with him. Steve commented:

> Then he told me one day that he was having family problems and that he'd call me when he gets back from, I'm not sure where. I think he had to go out of the country or state or something. He didn't call me for a while. And then he finally called me and said he had to take care of something but I don't know if he went or anything. He said he'd call me in a couple of days and he never called. Then he called me two or three weeks later and we just never connected.

Steve explained that they sort of played delayed phone tag but that because it had been so much time, he did not put too much effort to reconnect with Lewis.

Steve stated that he really responded well to the speaker who he felt was a mentor when he came into the career class. The speaker was a young adult who experienced psychiatric disabilities and was definitely a peer role model for the participants, much like the mentors. Steve shared, "I liked it when you brought speakers in, especially Ryan. He told us about his life and how he's doing on his own. I thought that was great. I was amazed when he told us his whole life, and how he had his own apartment now." Steve was struck at how much the speaker had been through and how he was able to openly share so much of his story to help others. Steve explained:

> He said he didn't really grow up in a nice home. He didn't have much. He just had all these problems, like being medicated for the wrong things because they couldn't figure out what it was. His girlfriend was pregnant, got beat up and lost the baby. And then he made fun of himself so people could laugh. He went to high school and got straight A's with honors, and that made him feel better about himself. He has a good job at Comp USA. The question I never asked him is how he affords the apartment. Because he probably only makes a little more than me. I meant to ask him that.

Steve commented that the "biggest impact on me was when the kid came in and spoke. That was like the turning point for a lot of the kids." Steve stated that this speaker was

"an inspiration" and gave him the sense that made him "want to concentrate on going to school, getting a job, and doing it all on my own like he did."

Richard. Richard expressed his dissatisfaction with his mentoring experience. He was frustrated and disappointed that his first mentor, whom he had a strong connection with, experienced a psychotic break. Richard declared:

> My experience with mentors was I hooked up with my first mentor and he lost it. Then I hooked up with a second mentor and I thought I was further along than he was. I really don't have any faith in this mentoring thing.

Richard was referring to the fact that his mentor had a nervous breakdown and had to abruptly end his mentoring commitment. Therefore, Richard explained that he lost faith in the mentoring piece of the program.

The Mentor's Perspective on the Mentoring Process

The Mentor Alice's Thoughts on Betty and Nancy. When asked what impact the experience of mentoring has had on her life Alice responded:

> It's had a really amazing impact on me. My experiences were with bipolar disorder, and I would always look at them in a negative way, but now I can look at them more positively as I can use them to contribute to someone else's recovery. It's helped my confidence a lot. It's nice to know that I could get along with people who were younger than me, I liked that. They opened me up to their world and their speech and I really appreciated that. It's so much more fun at their age, when things are still really new. Just the idea that I did have something to give is really major for me. It really is cool.

Table 9. Participants Guide

This table shows a detailed view of each mentee's primary diagnosis and the identifying characteristics that best describes them

Name	Primary Diagnosis	Identifying Characteristic	*Y/ N
Miranda	PTSD	Wants a sense of belonging and GED	Y
Nancy	PTSD	Wants to be a medical assistant	Y
Alison	bipolar	Wants to be an Engineer	Y
Bob	schizophrenia	Wants to be a teacher	Y
Tom	bipolar	Working at a book store	Y
Jessica	PTSD	Enjoys concrete and hands on learning	Y
Debbie	schizophrenia	Like the "connectedness" of the program	Y
David	bipolar	Architecture degree	Y
Amanda	anxiety	Musician/Attends Berklee School of Music	Y
Rudy	schizophrenia	Internship-radio station	Y
Steve	bipolar	Works as a dishwasher/ attends college	Y
Betty	bipolar	Artist	Y
Erick	bipolar	Fascination with condors	Y
Sam	PTSD	Wants to be a doctor/needs GED	Y
Janet	bipolar	In Engineering program	Y
Ralph	bipolar	Wants more connection to others	Y
William	ADHD	Wants to be a record producer	Y
Mark	bipolar	Wants a job, any job	Y
Richard	bipolar	Wants more concrete job help	Y
Frank	schizophrenia	Wants a GED	Y
Jim	PTSD	Wants to be a Chef and go to college	Y
Cyril	schizophrenia	Wants a GED	Y
Wanda	schizophrenia	Dropped out/Wants to locate more supports	Y
Kara	bipolar	Dropped out/Wants to feel more connected	Y
Jennifer	depression	Dropped out/ Works at a candle shop	Y
Missy	schizophrenia	Dropped out/Strong faith in religion	Y
Robin	PTSD	Dropped out	N
Joseph	schizophrenia	Dropped out early	N
Cindy	depression	Dropped out early	N
Patrice	depression	Dropped out early	N
Beatrice	bipolar	Dropped out	N
Dan	depression	Dropped out early	N
Dillion	bipolar	Dropped out	N

*Final Interview status-Y=Yes and N=No

When asked how did she think she was supportive or helpful to her mentee, Alice responded:

> I think that I was able to listen to them without being judgmental. More than staff or parents, I was more of a person who wasn't there as a professional. That helped the trust basis a lot. Not expecting them to rush in and do anything. Both of them put themselves on a lot of fieldtrips. What I was going through myself, trying to get a job, helped them. That whole culture thing: now that you're in your 20's you have to go to college or get a job. Sometimes disruptions in your life aren't as bad as you think that they are. I was able to help them realize that a little bit better, so they could feel a little bit better about themselves.

When asked were there any aspects of mentoring that she found challenging Alice responded:

> I think the way I went about it at first: I wanted to fix everything for them. I really had to watch my boundaries and not feel that I had to solve things for them. They taught me that – when I tried to give suggestions one of my mentees was so resistant to that. I knew it was the best thing for her to have, but they may not be able to hear it at that time. I guess the whole taking it slow process. I thought it would go a lot faster. I've known her for a year now, but I still don't know her that well.

The Mentor Claire's Thoughts on Rudy, Debbie and Jessica. When asked what impact the experience of mentoring has had on her life, Claire responded:

> I think that I've been impacted greatly. Having the three young women that I mentor was great for me because it brought me back to where I was at that age, and it made me think about if I had had that opportunity to work with someone, I would have done things differently. It gives me a sense of confidence to know that these women looked up to me, and even though I was a little older than them, we could still go out and have fun. So, I think it may have helped me as much as it helped them.

When asked what advice would she give to future mentors, Claire suggested:

> Have a lot of patience and try to think about what you were like at that age. You didn't like to talk about yourself and could be shy. Also, bring it down to their level, let yourself have fun with them. You don't always have to go to the library. Sometimes a trip to the mall is just as helpful.

When asked if there was anything else she wanted to add, Claire offered:

> Definitely more icebreakers at the beginning, because I still have a shy part of me, and a forced relationship that you think is going to work out might not. I really loved it, and I grew a lot this year by helping someone else.

The Mentor Kate's Thoughts on her Mentee, Amanda. When asked what impact the experience of mentoring has had on her life, Kate responded:

> I think the things that really struck me were that this role has more responsibilities that the therapy role I used to be in. I never felt responsible in the therapist role; my job was to just give feedback and to accept. This was much more like something was riding on me in this relationship. I felt like I had to be a bit more intrusive. I had to be really aware all the time that I had a specific purpose in the relationship and I needed to help them with something specific, like going back to school or getting a job.

When asked what has she has learned about herself, Kate responded:

> I don't feel like anything new has been revealed, but I feel that I usually try to avoid taking on so much responsibility with people in my life. I knew when I signed on with this that it would make me do a little bit more. Also, I learned about developing feelings for someone who you are helping. How personal you take the outcome. You might see all kinds of potential and how to take yourself out of the equation. But if you subtract too much of yourself from the equation, the other person will only get a hollow shell. It's always difficult for me to let myself be intruded upon, and give some personal parts of myself and acknowledge feelings for another person. This has been an opportunity for me to see things about myself. And being in a relationship with friends. Friends give each other a lot of slack. Therapeutic relationships with an agency allow you to hand off your client if you are leaving, but that's not how it is here. We have to put physical structure around our relationship. The training helped because I could talk situations over with the other mentors to get their thoughts and ideas.

When asked how has the relationship changed over the course of the project, Kate responded:

> It did change pretty early on, as we were learning about each other. I'm not sure it's changed that much once we got to know each other. Now she's taking a math class for people who don't feel strong in math and

> I've been acting as an editor and proofreader for her. I'm more in a tutor role in that aspect. She was showing me applications and asking for feedback. She's asked me to check her resume and make suggestions. That part hasn't really changed. At the beginning, it felt to me that I would offer feedback and she wasn't listening. I didn't know how to help. But I didn't want to say anything heavy or be bossy. And then at a certain point, I just started asking her what she thought about things, and the relationship grew. But there's still a formality about the relationship.

The Mentor Al's Thoughts on David. When asked what impact the experience of mentoring has had on his life, Al responded:

> It's allowed me to give back in a social kind of way and recognize the limitations I have, and things I have to deal with myself that are socially related and my ability to really reach out to people. It's maybe allowed me to think about myself and who I am and who I want to be and made me wake up. I've also been impacted by the power of the project and how I've seen it impact people's lives in a real positive way. I've been very impressed with the other mentors from what I can see, how they stuck with it, and with their mentees. The graduation was amazing to me, it really blew me away to hear people go up there and share their experiences, and also seeing the families in the audience. That impacted me as a mental health consumer, as I have been there. It's a wonderful project.

When asked what did he think has been the most valuable aspect of being a mentor, Al responded:

> For me, it's giving back and trying to offer some help that I at least at that point in my life was not ready for. Trying to just give that unconditional acceptance, giving back, and I think a lot of us who deal with mental illness get into self harm or self hate, and it's nice for me to try to give positive feedback. For me, the other piece was that at one time I really wanted a mentor and never had one, and I've always felt kind of critical that people were not making themselves available. So for me, it's important to offer something.

The Mentor Mary's Thoughts on Sam. When asked what impact the experience of mentoring has had on her life, Mary responded:

> In a lot of ways. One of the big things that's challenged me is to always keep an eye on my own recovery. Where I am and how I'm doing. Because I can't be there for someone else unless I'm doing well. I've

> gotten a broader and better sense of just how disjointed the system is for young adults. I knew that on an intellectual level from my other job, but now I've seen it a lot closer. I've seen in with the two young women I've worked with. I've also been tremendously touched by how much impact I've been able to have in her life. She really counts on me for support – she pretty much contacts me every day. She's afraid that I'm not going to talk to her in September. Just seeing and feeling that impact. Because most of what I've done professionally as an adult has been administrative. But I can now see I'm making a difference.

When asked how have you been most helpful to your mentee, Mary responded:

> I think just by being there. Not a day goes by that we don't either talk or leave a message for each other. She been through some really hard times and I've been able to stick with her. I don't think she thought I would. And also doing fun things with her. We've done some GED stuff, and some one-on-one stuff, like when she was in the hospital; I try to keep her feeling like she's moving forward. She's been out with my friends and me when she's out of the hospital, and she can talk to my friends. Now she likes hanging out with my friends, and it's expanded her life a bit. Just being able to make connections with other people.

When asked what do you think has been the most valuable aspect of being a mentor, Mary responded:

> Being able to make a difference. Sticking with somebody that is valued. Even the other mentee that I'm working with, who I've had very little contact with in the past six months. We did lots of things at first, but now she only occasionally calls and she still knows I'm there, which is important. I've also enjoyed working with the staff here. That's been a broadening thing for me, having a chance to get to know some different people. Some of the other mentors and mentees I've developed a little relationship with. You and Sasha too. I really feel I've gotten a valuable life experience working with you guys. Being able to call and get the supervision from you and Sasha. I feel I've learned a lot about how to work with services that aren't always clinical. I've never really liked the clinical model, the boundary issues, etc. They always sat badly with me. To see this other way to provide support has been very valuable.

The Mentor Aris's Thoughts on Bob. Bob started off with his first mentor Carl, who was in his career field and they connected well. Halfway through the program, Carl started a new job and got involved in a new relationship so he felt that he did not

have the time or energy to be a supportive mentor to Bob. After Carl resigned as a mentor, Bob was connected to Aris for a mentor, who was closer to his age. Bob and Aris had a lot of fun together, hanging out, exchanging stories and playing pool. When asked what impact the experience of mentoring has had on her life Aris responded:

> I've learned the way different personalities are, like when he needed a job and I can give him advice to start it like I did. I learned more about myself when I was in his position. When I was in his shoes looking for a job, I remembered when I was there and what I did.

When asked how do you think you've been most helpful or supportive, Aris responded, "Just by listening to him when he's talking about his job or life. Being a friend and talking about experiences that we both had, we could relate. We also like to joke around. Just asking questions and listening to him." When asked what do you think has been the most valuable aspect Aris responded, "giving back".

The Mentor Stacey's Thoughts on Janet, Alison and Erick. When asked what impact the experience of mentoring has had on her life, Stacey responded:

> Well, my experience with Janet has been great. That was just good luck with a good match and I think the match is very important and pretty hard to predict in most cases. But this was an easy one because of what I do and what she wants to do. But there are challenges around that. As much of a relationship I wanted to build, it was hard to get her to open up when things were really troubling her. She backs off when things bother her and I have to respect that. She's doing so well at the engineering program and she's going into her internship. She's a great person and she's been through a lot in the past year. She's very bright and she'll do well.
>
> My relationship with Erick was interesting. I liked him very much and I think he liked me too. But I think his confusion about which way to go made it difficult for him to show up for appointments with me. But when he did, we had great conversations. I still have lingering feelings about ways to give him a push, because I think he's just stuck. I even advised him that to get unstuck, sometimes you just have to pick one direction. It might not work, but you can just pick another direction. I could tell he just wasn't getting what he wanted out of the relationship. I

don't think he knew what he wanted. I think the relationship was great. It was a pleasure getting to know him. I had two main people, one mentee that I had a lot in common with, and the other I didn't have a lot in common with and that was great for me. It made me focus on the different things I got out of it. I think it shows it can work if you really are interested in getting to know this person.

Alison and I have amazing things in common, and also amazing differences. She's pretty straight-forward: she asks for what she wants and I don't think she wants a deep friendship. It's more task oriented, will you do this or that with me? I hope that changes, but I think I know where it's coming from. I think she's had issues with boundaries before and I can respect that. But she's a wonderful young woman and I'm learning a lot from her. I'm very interested in spirituality and religion and I'm learning about her religion and how it made a difference in her life. So she does share, but she doesn't want me to get into personal things. But that's fine. So there's three and it's been wonderful.

When asked if there was anything else you want to add Stacey responded:

I think in mental health, mentoring, advocacy, and bringing consumers into the field is the way to go. It's the kind of disability that leaves you with an expertise about some of the challenges involved. From the inside out. And not only how to cope with the challenges, but you are left with this enormous boundary of knowledge with dealing with the systems that you have to work with. The bureaucracies, case managers, and social workers. I think consumers who have dealt with that are ideal as mentors because they know how to work within the system. The most invaluable piece is the hope and believability of really having been in a place and overcome. Most of the people that work with people with mental illness either do not have this expertise or are not allowed to say so. So you don't know whom you work with. And there's still a lot of ignorance out there.

When asked what has she learned about herself Stacey responded:

I really think my own hesitations and my own sort of inability to get started and wanting or expecting too much. I see all these things reflected in each meeting. When you tell someone to do something that you're not doing yourself. Wow! What an eye-opener. But when you address it, it makes it easier to get past it. I got energy from cheering someone else on. My frustration with Alison right now is that she wants to lower her career goals because she thinks she can't reach them. And that frustrates me because I always wanted to go to get a Ph.D. But I want to tell her not to sell herself short. There's no reason when she's so young and so bright to not still consider it. Go for your goal.

Stacey was the mentor for three participants, Alison, Janet and Erick. Stacey had three completely different relationships with each one. Stacey explained that she felt a close connection with Janet because they had the engineering interest in common and they spent a lot of time together around Janet being effective in that environment. Stacey felt that she was a valuable support in Janet's vocational recovery. Both Stacey and Janet felt it was a "good match" that worked well.

Stacey stated that although they both tried, Erick and she never made a solid connection so she was disappointed that she never was able to help him become "unstuck" in his vocational recovery. Stacey felt that she was not able to support him in the way he wanted to be supported. In fact, she was not even sure he knew what that was. Stacey stated, "I could tell he just wasn't getting what he wanted out of the relationship. I don't think he knew what he wanted."

Stacey stated that she and Alison had "amazing things in common" and also "amazing differences." She stated, "she's a wonderful young woman and I'm learning a lot from her. I'm very interested in spirituality and religion and I'm learning about her religion and how it made a difference in her life. So she does share, but she doesn't want me to get into personal things. Stacey stated that their mentoring relationship was more "task orientated" where in her relationship with Janet the support was more personally focused.

Stacey noted that she learned a lot from the mentoring process especially around the idea that one must practice what they are teaching others to do. Stacey stated, "I really think my own hesitations and my own sort of inability to get started and wanting or expecting too much out of myself and others. I see all these things reflected in each

meeting. When you tell someone to do something that you're not doing yourself. Wow!" Stacey stated that the mentoring relationship brought her to a higher degree of self-awareness and promoted her to take more action towards her goals in her own life. Throughout the mentoring process, Stacey worked hard to be the most supportive and enthusiastic mentor possible. Stacey stated, "I got energy from cheering someone else on." Stacey enjoyed working with all her participants'. She stated, "so there's three and it's been wonderful."

Summary of the Importance of the Mentor Connection.

The participants stated that the support of the mentors was very important to their development and vocational recovery to the participants who chose to take advantage of it. For the participants it provided a real sense of support and strong feelings of being accepted and understood. These participants stated that knowing someone who had experienced psychiatric disabilities and had gone on to have a productive life and a successful career gave a tremendous amount of hope and guidance. For the most part, the participants acknowledged that the mentors tried to meet their needs, although sometimes they were unable for various reasons. The participants' resonated with the idea that their mentors had similar challenges to the ones they were facing. Some mentors reached participants' that no one else could really connect with. Ralph for example did not relate or interact well with his parents but seem to really relate well to his mentor, Gary. The best mentor matches and/or staff connections seemed to be when there was an element of respect and/or admiration from the

Table 10. Guide to Mentors and Participants

Mentors	Interview Status	Participants
Alice	Y	Betty and Nancy
Claire	Y	Rudy, Debbie and Jessica
Kate	Y	Amanda
Al	Y	David
Mary	Y	Sam
Aris	Y	Bob (2nd mentor)
Stacey	Y	Janet, Erick and Alison (2nd mentor)
Lily	N	Miranda
Gary	N	Ralph
Ellen	N	Patrice
Edward	N	Cyril and Richard (2nd mentor)
Carl (Dropped out – midway into program	N	Tom and Bob (1st mentor)
Lewis (Dropped out – midway into program)	N	Cyril and Frank
Annie (Dropped out-midway into program)	N	Alison (1st mentor)
Travis (Dropped out-beginning of program)	N	Jim, Dan, Richard (1st mentor)
Harry (Dropped out-beginning of program)	N	Steve (1st mentor)
Mandy (Dropped out-beginning of program)	N	Kara

participants' perspective. Amanda respected and valued her mentor, Kate, for "everything, not just one thing." Erick admired his job developer,

Jaffray, not only because she helped him but because she was an artist. Janet greatly valued and appreciated Stacey's support because she connected her to her desired vocational support and stayed connected to her so she could continue to be effective. Janet was also was thankful of her many other supports. Richard greatly valued the co-manager of Jump Start, Sasha's support and respected very few other people in his entire support system. The ability to recognize, develop and appreciate supports was a critical skill that kept coming up for participants and it would be a critical question that could be developed in a future study.

According to the participants, peer role models in the form of mentoring has been a critical piece to their development and vocational recovery because just having someone like Debbie stated "just to be there", or as Rudy stated "as an activity buddy." Miranda summarized the value of mentoring for her very well: "the support, it's good to have someone who's been through something and is out there making it. It gives you motivation." The mentors meant different things and met various needs of the participants', but overall the participants' felt that some of the critical elements to their developmental and vocational recovery were having someone there to listen to them, to be there for support, to give guidance or direction when asked, to do things with or just to be a living example of hope of what can be achieved.

Mentoring Relationships Impact on Attrition Rates

The participants who remained the least connected to the program either were never connected with a mentor, their mentor connection did not work out either because of location or transportation issues, or they chose not to have a mentor. The mentoring

piece has been so important in so many facets of the program, but it has been most critical in keeping the participants' connected and engaged in the program. When most participants' symptoms were so severe that they could not come to class, the mentors either kept emailing, kept calling, visited their houses, met them closer to home or engaged them in a low stress activity that they felt they could do at that time, like going to the movies or for a cup of coffee. Since the mentors had experienced psychiatric disabilities themselves, they were meeting the participants' at a unique self-referential place and the participants' felt drawn to that. The participants' continually spoke about not being judged and being understood by their mentors, which they stated was extremely important to them. The mentors helped keep participants' connected in a way that the more traditional forms of program supports like classes, staff meeting and social events have not been successful.

Mentoring from the Mentor's Perspective

The mentoring relationship has made an impact on the recovery process of the mentors. The mentors shared some of their thoughts in their own words about how the mentor experience has shaped and positively influenced their lives. The mentors talked about the importance of meeting their mentee where he or she was at this point in their development. The mentors understood their role as a support, an active listener from a place of non-judgement who was there to share their participants' recovery journey and at times offer insights and guidance when asked.

Overall, the mentors welcomed the young adults' participation on their own journey of recovery. The mentors stated that there was a valuable exchange of ideas,

knowledge and activities that had some qualities of friendship and some aspects of an authority figure who possesses a lot of compassion and care. Most of the mentors stated that it was a positive experience in which they learned a lot about their own capabilities and vulnerabilities as well as their mentee. The most significant mentor theme was the concept of how the opportunity to give back enriched the mentors' lives and enhanced their own recovery.

The Quantitative Results Section

The Recovery Attitudes Questionnaire (RAQ) has seven questions measuring self-reports of attitudes about recovery from psychiatric illness and its consequences (Borkin et al., 1998). The RAQ-7 was developed to compare attitudes about recovery among different groups such as consumers, mental health professionals, family and the public at large (Borkin, et al., 1998). The mean overall score at baseline was 1.9780 ± .42 and at endpoint was 1.7582 ± .41. The score went in the predicted direction and approached significance ($p = .059$), and indicated a trend in the desired direction. The mean RAQ factor one score (example item: "To recover requires faith") baseline was 2.04 ± .52 and at endpoint was 1.8533 ± .10. The score went in the predicted direction and approached significance ($p = .199$). The mean RAQ factor two (example item: "People differ in the way they recover from a mental illness") score at baseline was 1.8974 ± .74 and at endpoint was 1.6667 ± .60. The score went in the predicted direction and approached significance ($p = .922$).

Table 11. RAQ- Paired Samples Correlations

	Mean	Std. Deviation	Std. Error Mean	T	Df	Sig. (2 tailed)
Pair Pre-raq total score 1 Post-raq total score	.2198	.5660	.1110	1.980	.25	.059

Interpersonal Support Evaluation List. The Interpersonal Support Evaluation List (ISEL) contains 40 questions that query perspectives about the types and levels of an individuals' social support (Cohen & Hoberman, 1983; Cohen, Mermeslstein, Kamark & Hoberman, 1985). The ISEL was designed to evaluate the perceived availability of four separate categories of social support as well as providing an overall support measure. The items comprised in the ISEL were divided into four 10-item subscales. The four categories are as follows: 1) appraisal items- the perceived availability of someone to talk to about one's problems; 2) tangible items - perceived availability of material aid; 3) belonging items-perceived availability of people one can do things with and 4) self-esteem items-perceived availability of a positive comparison when comparing one's self to others.

The mean overall score of the ISEL at baseline was 1.9679 ± .43 and was 2.0746 ± .40 at endpoint ($t = -1.394$, $df = 25$). The score went in the predicted direction and approached significance ($p = .003$), and indicated a trend in the desired direction.

Table 12. Total ISEL Score- Paired Sample Statistics

Mean	N	Std. Deviation	Std. Error Mean
1.9679	26	.434743	.08579
2.0746	26	.395580	.07762

Table 13. Total ISEL Score -Paired Sample Correlations

N	Correlation	Significance
26	.565	.003

Table 14. Total ISEL Score -Paired Sample Tests

Df	Sig. (2 tailed)
25	.175

The mean ISEL score in the appraisal category was 2.1681 ± .12339 at baseline and 2.1937 ± .09831 at endpoint (t = -.265, df = 24). This difference was not statistically significant (p = .793), but did indicate a trend in the desired direction. The mean ISEL score in the tangible category was 2.0859 ± .10669 at baseline and 2.1480 ± .10281 at the endpoint (t = -.675, df = 24). This difference was not statistically significant (p = .506), but did indicate a trend in the desired direction. The mean ISEL score in the self-esteem category was 1.7904 ± .11573 at baseline and 1.8804 ± .07571 at the endpoint (t = -.961, df = 24). This difference was not statistically significant (p =

.346), but did indicate a trend in the desired direction. The mean ISEL score in the belonging category was 1.8662 ± .13071 at baseline and 1.97581 ± .13432 at endpoint (t = -.864, df = 24). This difference was not statistically significant (p = .396), but did indicate a trend in the desired direction.

Table 15. ISEL Paired T-Test for pre-post Subscales

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	PRE-Appraisal	2.1681	25	.61693	.12339
	POST-Appraisal	2.1937	25	.49156	.09831
Pair 2	PRE-Tangible	2.0859	25	.53347	.10669
	POST-Tangible	2.1480	25	5.1407	.10281
Pair 3	POST-Self-esteem	1.7904	25	.57867	.11573
	POST-Self-esteem	1.8864	25	.37853	.07571
Pair 4	PRE-Belonging	.18622	25	65353	.13071
	POST-Belonging	1.9758	25	.67161	.12432

Table 16. ISEL Paired Samples Test-Paired Differences

	Mean	Std Deviation	Std. Error Mean	T	Df	Sig (2-tailed)
Pair 1 PRE-POST-Appraisal	-0256	.48315	.09663	-265	24	.793
Pair 2- PRE-POST-Tangible	-0621	.45987	.09197	-675	24	.506
Pair 3 PRE-POST-Self-esteem	-0900	.46842	.09368	-961	24	.346
Pair 4 PRE-POST-Belonging	-1136	.65741	.13148	-864	24	.396

Summary

Although each in-depth interview with participants and mentors yielded variations in individuals' experiences, the emergence of nine themes across interview were identified as essential components to the recovery process. Until now there was a very limited understanding of how interactions with key supports contributed to the development and vocational recovery of young adults experiencing psychiatric disabilities. The quantitative information was an important first step in the data collection process of this research, yet the qualitative data provided an important glimpse into the experiences of these young adults with severe psychiatric disabilities at this moment in time. Specifically themes across interviews revealed the important impact of presence and absence of supports in regard to situated learning, interaction with places, professional, family, staff support and the role of mentoring a peer model support. The compilation of these findings are so significant because they capture the unique perspective and meaning-making process of the young adults with psychiatric disabilities in a rich and comprehensive way through the students own articulations of their recovery journeys.

CHAPTER 5

DISCUSSION

Introduction

From the historical and theoretical analysis, it is clear that all development takes place in relationship, develops in a context, and must take into consideration the individuals' past history. The research on young adults with severe psychiatric disabilities begins to ask the right questions, but has not yet conducted enough research with the young adults themselves in a way that is responsive to their unique educational and support needs. Anthony et al. (1990) state "that it is critical that supported education be done with students, not to students." In support of this, Deegan states, "students must be active and courageous participants in their own rehabilitation" (1998, p. 12).

The research conducted so far is lacking in research on young adults' difficult transitional period to adulthood and does not account for the importance of the participants being able to create and maintain their own level of natural supports, nor has it evaluated how this could potentially impact vocational outcomes. This research needs to be conducted. The current research model lacks focus on educating or drawing out participants in a way that cultivates and develops their existing competencies. The goal of psychiatric rehabilitation research can be brought to the next level to build upon participants' own natural social support networks and existing capacities to assist them in achieving their optimal level of growth and development (Bisset, 2000).

All these research studies, NLTS, NACTS, McGraw Center, and the Young Adults in Community Study (YAICS), used quantitative data to evaluate the young adults experiencing severe psychiatric disabilities, but do not ask the participants themselves to articulate what programs or experiences would be helpful to them in their own development and vocational recovery. In contrast, this qualitative view is critical to creating a comprehensive picture of what would effectively assist participants' transition into adulthood.

Unlike other research studies that examined young adults with severe psychiatric disabilities, the participants in this research were asked what they felt would make the greatest difference in their vocational development and recovery. The focus of the research was on those who were able to articulate what the experience during the last year has been like for them. The research did not capture the experience of all the participants in the study or all young adults with severe psychiatric disabilities in the United States. The goal was to create a small glimpse of a moment of time, or a string of experiences over the period of approximately one year to help inform the perspective of young adults with severe psychiatric disabilities.

Another goal of this study was to understand what supports helped or hindered the coping strategies of the participants. The aim was to understand the underlying factors behind a positive step forward or a step back, to try to interpret the meaning-making process of the events with the participants. In the interviews, the participants reflected upon the role of situated learning and meaningful work in their lives and the significance of the presence and or absence of critical supports. In order to accurately

represent the participants, quotes of these participants were used to honor their lived experience of the last year in response to this program at this stage in their lives.

The fact that this research was presented in the words of the participants reflected the commitment of the study to determine what was the most effective way to transition these participants to adulthood. Unlike other research, this study encouraged the participants to be involved in the development of the program and then asked them what worked and did not work for them in their development and vocational recovery. This makes the research construct unique in two ways. First, the participants were encouraged to participate in the development of the program and second the participants' thoughts and ideas, not the researchers ideas of what was important, were incorporated in the research. The themes articulated by the participants reflected the priorities and objectives that they felt were important for their vocational development and recovery. These results will have important implications for the recovery journeys of these participants as well as other young adults with severe psychiatric disabilities.

Discussion of the Results of the Research Questions

The study found that the participants revealed nine significant themes that impacted their vocational development and recovery. The themes were organized under the three research questions of the study. The first research question inquired about the participants' experiences with situated learning and found that participants wanted specific and tangible situated learning activities that allowed them to take positive steps in their recovery. The second research question focused on the participants' interaction with supports and found that place, professional, family, staff and peer supports played

important roles for the participants. The third research question concentrated on the significance of the mentoring relationship and found that the mentoring experience made a measurable difference in the lives of some of the participants and their mentors.

Yet, the participants stressed that it was these supports combined with the opportunity to take action in their lives through interactive classes, social activities, volunteering, internships, and working that really made a difference in their development and vocational recovery. This combination of factors has increased many participants level of readiness to a capacity that enabled them to build on their successes through enhancing their confidence and competence in the moment. The participants stated that these gains then began to build upon one another and led to greater progress in their development and vocational recovery.

Discussion of Research Question One

Research Question One: what were participants' experiences with situated learning in their vocational development and recovery? Young adults with severe psychiatric disabilities need hands-on experience with productive and challenging situations (Davis & Vander Stoep, 1997). Young adults with severe psychiatric disabilities also require appropriate educational and employment support to enhance their existing capacities to meet the demands of their new environments (Hutchinson et al., in press). The three themes that are categorized under this research question are as follows: 1) Participants wanted situated learning experiences; 2) Participants desired tangible supports and hands-on learning opportunities; and 3) Participants sought ways

to take positive steps toward their own recovery. The three themes are discussed below using participant quotes to further clarify and elaborate on the research question.

Theme One and Two: Situated Learning with Tangible Supports

Miranda demonstrated a good example of the power of the first theme of situated learning when she stated that she "liked the activities part. That was always good." Miranda enjoyed being connected to the staff and other participants in a structured and organized way. Miranda stated she enjoyed "being involved in the community. Like when we went volunteering. I like to make an effort to help others. It gives me a sense of belonging." Miranda was affirming that she really wanted to connect with others and feel that others were connected to her. Miranda felt a tremendous amount of satisfaction when separating cans at the food bank. Miranda loved working side by side both with staff and participants for what she felt was a worthwhile activity. At the end of the night, the head staff at the food bank calculated how many cans we separated out and repackaged and how many people would be fed at local shelters and soup kitchens. Miranda experienced a lot of pride and satisfaction in hers as well as the group's efforts that evening.

Miranda's experience demonstrated that meaningful learning opportunities do not take place in the classroom but in the context of actual situations that have relevance for the individual, which is the foundation of situated learning. Miranda expressed that being situated in a learning environment like volunteering at a food bank was a great match for her objectives in the program. Miranda stated that going to separate cans at the food bank was her ideal activity and that she wanted to have lots more events like

that one. Miranda explained she wanted to feel like she was meant to be somewhere. Miranda felt like her presence at the food bank mattered and that she achieved something worthwhile during the time she was there. Miranda continued, "Like not just here, but in the world." Miranda was struggling to find a sense of herself and a context that was meaningful to her when she stated, "there are so many questions, like do I have a place?"

The activity was hands-on and concrete, which worked very well for Miranda but at the end of the activity another layer of meaning was added. At the end of the night, the entire group of volunteers from various schools and organizations sorted 14,087 pounds of food, which meant that each volunteer made 247 meals possible. Miranda explained that hearing the number of hungry people that would be fed made it a rewarding experience for her in which she felt more connected. Miranda stated that the community service activities assisted her in her development and vocational recovery through helping her connect with the other volunteers and to the larger community around her. Many participants stated that they had a strong desire to give back to the community and the program. Participants were continually seeking more concrete ways to contribute their unique skills and talents in a positive way.

Throughout the program, the participants expressed their need to connect with one another outside the classroom and in a friendly and fun way and the program responded. William stated that he liked "the bowling." Ralph stated that he liked "playing pool with my friends. It feels more comfortable." Jump Start participants, staff and mentors collaboratively planned outings and activities to promote self-esteem, community connections, and opportunities to socialize. These events ranged from

bowling, billiards, a benefit walk for the Massachusetts Society for the Prevention of Cruelty to Animals and the Angell Memorial Animal Hospital, A Friends and Family Event, to educating and sharing ideas about recovery and hope, volunteering at the Boston Food Bank, softball games, and attending local sporting events. These events were critical for the participants because it gave them opportunities to develop their social skills and relate to other participants on a more personal and less structured way. Many important peer supports were created and/or fostered through these social events. What many programs fail to realize is that participants develop skills in lots of unique environments and that social activities have a large impact on participants' development. Learning is most effective when the participants are highly interested and engaged in activities, which often occurs when participants are engaged in activities that they enjoy doing.

Another powerful example of the theme of situated learning took place at the internship site, evidenced when Rudy explained the significance of her internship on her development and vocational recovery. Rudy felt that her internship at the radio station helped her reconnect to aspects of her life other than her family. Rudy reported that she was extremely happy with her internship because it was the setting she requested and she loved being connected to that environment. As Rudy said: "I liked it a lot. I'm actually still kind of involved in the station a little bit. I'll still get emails from them about different events going on. I'll go with my friends to different events." Rudy noted that after she interned at the radio station she became less isolated and withdrawn. Rudy explained that she was situated in the perfect context for her to use skills that she had not used since she had to leave college due to her psychiatric disability. "It's been

helpful being out of the house because I've got a new perspective on things and I think less about what I'm recovering from and more about the present moment." Rudy explained that she used to have extreme difficulty using the phone but one of her main tasks was to make "phone calls to people. Mostly it was phone calls. I mostly called people to tell them about events on the phone." Rudy explained that she was able to deal with her phone anxiety, which had been a big problem in her life and actually make calls for the radio station. Rudy surmised that is was "a very good phone experience." Rudy explained that because it was an actual real life setting, she was able to push through her fears and anxiety and perform the skills necessary to stay at the job because she wanted to be successful and was tired of sitting at home feeling disconnected and scared. Rudy concluded that she thought she "learned that I am more capable of doing more things than I thought I was." Rudy concluded that she thinks this level of learning and self-discovery was possible because "it's getting away and being put in an environment where I can be successful." Rudy believed that being put in an environment of her choice that she was interested in and excited about helped her create her success.

An important classroom example of the second theme of tangible support was when David talked about developing his own personal web page. David saw the web design page as his "own thing." David commented on his own personal connection and pride about the web page in development. David explained, "the web design class also helped make a website, getting it together and up and now I'm a lot better at computers. I'm a lot better at computers just because I took classes and seem to be doing a lot of computers now at my house." David reported, "I liked Web Design more because it

introduced me to HTML code and the web. It's a really good skill to have." David explained that he took the skill he learned in the Jump Start classroom and applied them to his learning environment at home. David viewed the web design skills he learned at Jump Start as transferable and marketable skills that he can use in the future. David shared, "I liked how we were making resumes and trying to find jobs." He noted these activities were "very important." David commented that these learning experiences of web design class and creating resume and job search tools, were a great match for him because he could directly relate to what was being taught in a hands-on way, and he could immediately see the practical application of the skills he was being taught. In contrast, David did not like "the beginning of the program where we weren't really doing as much and towards the end it was more like we're going to help you find jobs or colleges."

David revealed the importance of theme two, tangible supports, as a common theme voiced by many participants. David commented that he wanted to learn interesting and marketable skills like computers, web design and career development in a hands-on detailed and concrete way that was personally relevant to him. He remarked that he did not want to learn the theory or talk about the values around choosing a career. He wanted to just get a job. Making his own web page and creating his own resume were direct reflections of this specific learning style and skill need.

An important example of how the first theme of situated learning and the second theme of tangible supports were interrelated and directly applicable to participants' specific interests was the Living Well seminar. The seminar was designed to assist the participants in their health and wellness goals. Topics included meditation and

mindfulness, journaling, yoga, exploring how food relates to feelings, medication and symptom management, spirituality, sexuality, and life enhancing strategies for relaxation and stress relief. What was fascinating about this class was that it was considered extremely successful to some participants and a disappointing waste of time to other participants.

The reasons for this disconnect to the Living Well seminar were varied and personal. Many participants stated they were not ready to talk about their wellness goals or symptom management in a group setting. Some participants stated that in the beginning they did not trust the other participants. Other participants did not admit to having a psychiatric disability so they did not feel a need to attend the class. Still other participants expressed that the class was not concrete or specific enough to their desired learning style. Participants stated that instead of physically doing wellness activities such as Yoga or Meditation, they were frustrated because the instructors only talked about the seven domains of wellness. Some participants stressed that actually doing the wellness activities was the only way for them to actually understand and incorporate these wellness activities into their lives. For example, the students felt that they couldn't learn the importance of the stress relief in yoga if they were not able to try out the poses and then feel the release of tension in their bodies. Many of the participants were hands on or kinesthetic learners and wanted to be situated in the context and performing the activity. For the younger participants, in particular, this class was not what they wanted or needed at this point in their development and vocational recovery. Participants expressed that wellness class did not have value or personal relevance for them. Many participants just wanted a job, any job, and they stated that they didn't

need to learn strategies of coping. They just needed to get a job to get some money. According to those participants, life would be easier to cope with if they had a job and some money coming in. For example, Richard stated, "I ain't got time to just sit around and talk about it. I just got to do it."

Talking about issues of balance when many of the students were symptomatic and still trying to balance simple day-to-day living skills did not resonate with several participants. Some participants stated that talking about what it meant to be socially well or healthy was not helpful. Such exercises were futile because they asked participants to talk about how to maintain a friendship when many had none or to talk about water cooler conversation at work before the participants had a job. These participants explained that this type of passive and verbal learning had no relevance for them because it was not situated in a context that was applicable to many of their lives at that time. These students wanted to fully participate in their own learning and development, which is the point of situated learning.

In contrast to the participants above who were not interested in the wellness class, Alison declared that she loved the Living Well seminar. For Alison, the classes were actually at the level of development and specificity that she needed in order to optimize her recovery goals. Alison talked about the importance of having a classroom situated learning activity that had concrete and hands-on activities that she could be physically connected. Alison stated, "I think my favorite class was the wellness class" because she valued learning specific strategies and techniques that she could readily apply to her life. Alison noted that for her the wellness class was an ideal learning situation because it reflected her readiness level and attention. Alison was excited to

learn more about how to "recognize early warning signs", different ways of "expressing our feelings" and "expressing relaxation techniques".

The wellness classes that went over particularly well were the collage classes. In these classes participants created a story by cutting out pictures from magazines and arranging them in a way that helped to reveal parts of themselves, their goals and their dreams. The participants explained who they were and what recovery goals they were pursuing using the pictures that they had created. The participants' pictures reflected what aspects of wellness they wanted in their lives and then they explained to the class why this was important to them and how they were going to make it happen. Debbie stated learning "how to make collages" was very helpful to her. In agreement with Debbie, Jessica stated that she enjoyed the concreteness of the learning activities like the collages because she felt the person "can learn more about themselves and the other people that way". She liked "doing stuff while learning."

Alison declared, "I loved doing the collages and sort of exploring through art what we hoped to become, who we are right now and where we want to go." Frank, who had been quiet through almost every other wellness class, actually spoke out quite animatedly as he explained his carefully constructed collage to the rest of the class. He carefully explained in specific detail why he chose the pictures he chose and why he placed the pictures in which position and how the pictures in his collage related to what he wanted to achieve in his life.

Although Alison said that she loved the collages, she stated that her favorite activity in class was creating an emergency box for when she needed to take care of herself. She loved the idea of physically creating something she could personally use at

home with candles, pictures, poems or candy that could help her feel better. This strategy put her in more control of her own well-being and care-taking. Alison clearly enjoyed the process of learning while doing which is the precise concept of situated learning. Situated learning is practicing and doing the actual skills; ie, creating an "emergency box" that would help the participant cope during difficult times. Several other participants agreed with Alison and stated they also liked creating wellness toolboxes for when they needed things to help them stay well. Again, this activity was specific, concrete and applicable to the participants' immediate needs.

In contrast to the wellness classes, Alison had more difficulty with the career class. As many other participants agreed, it was challenging for her to sit and talk about her future in abstract and theoretical ways in class because her mind would wander and she would often get caught up in her thoughts. Alison stated "sometimes I thought that class was a little hard for me to follow and stay motivated because it was a lot of talking and a lot of conceptualizing and I guess I like to work with my hands, more of a kinesthetic learner." Alison speaks to the importance of having concrete tasks involving the participants in a very hands-on and active way in the career classes. The one task Alison really liked was learning interviewing skills because it was done in a concrete and interactive way through each participant doing a mock interview and the other participants giving specific constructive feedback in the moment to each participant. She also wanted the interviewing skills more spread-out so she could absorb them at a slower pace and have more opportunity to practice them over an extended period of time.

Erick agreed with Alison when he stated, "I guess, a lot of it is theoretical, ideas about stuff but not like direct plans. Telling you, okay go here and get a job here." Erick wanted concrete and specific help in looking for and actually obtaining a job. He wanted specific step-by-step instruction in detailed mini-steps on how to get a job. Erick stated, "hands-on. I was also thinking about homework, that I felt that wasn't sort of a bad idea. You know, having something to do." Erick expressed that he wanted to be involved in the process. Erick wanted homework to do when he was not in class if that would help bring him closer to actually finding a job. Erick revealed, "sometimes during class you end up just sitting there and you kind of like aren't getting anywhere." Erick noted his frustration with the level and type of support he received. Erick declared that this was not his desired learning situation because the class was passively talking about how to get a job, but he wanted to know what actions he could personally take right now to get a job that he would actually enjoy doing. He wanted to be situated in an active learning environment that was directly related to his vocational goals.

Alison, Erick, Debbie, and David's specific feedback along with several other participants' and mentors' feedback led the program to compose a new class. The participants' suggestions lead directly to the creation of a new Jump Start class titled Creating Success class. The goal of this class was to build on the connections and success participants experienced through Jump Start by exchanging information and experiences with others, learning about helpful community resources, and developing research and presentation skills. This new class was for both participants and mentors to learn strategies for producing more accomplishments in the areas of their lives that matter most to them including: where you live, what you want to do, who your friends

are, setting goals, managing time and money, or any other areas that are important to the participants.

Some participants thought the career, computer or wellness classes were too slow and they dropped out of the program because of it. The pace of some of the classes bored several participants or at times the content of the classes was not where they wanted it to be. Jennifer stated, "the computer class was good. The beginning was review for me. I kind of knew a lot of that stuff. I stopped going because I knew too much of the stuff and I was getting a little bored." Jennifer stated her frustration in wanting to learn at the appropriate level skill-pacing. Jennifer wanted to be matched at the appropriate skills level so she could be properly challenged and supported and would not feel that the classes were too slow or boring for her. Some participants viewed the classes in general as a waste of time because they were not exactly where they energies were placed. For other participants, for example David and Alison, the level of challenge and support in the classroom was exactly where they needed it to be in the development of their skills.

Many participants' voiced that they wanted the program to get them a job. For example, Cyril stated, "I'm looking for jobs now. I went to McDonalds, Marshalls, and D'Angelos. I want to know if you all can help me get a job?" Cyril was expressing his desire for a job and his concern around not getting enough support for his goals. In agreement with Cyril, Mark confirmed that he wanted more direct and personal support finding jobs. Mark stated, "career class should be more directly focused on helping people get jobs." Mark affirmed that he wanted lots of job development activities to take place like "phone calls to employers to set up accommodations." Mark also

pointed out that the classes should be about what participants want: "schools, jobs, or volunteering". This quote speaks directly to the fact that Mark, like many of his fellow participants, wanted to feel that they were in a learning environment that situated them in the appropriate context for the skills that they wanted to learn. Mark declared that he wanted to be in a class with people who had similar goals. Mark stated that participants with similar goals should have been grouped together and then created action plans that would help them achieve their goals. Mark thought it was a waste of his time to be doing activities that were not related to his goals.

The participants' remarks on wanting more direct and personal support finding jobs was a consistent theme throughout the research. In fact this was such a consistent mantra among the participants that the program changed the way its career classes were arranged to make them more individually focused and centered on job searching activities. Please refer to Appendix C for an explanation of this change in the structure of the career classes. For many participants, the shift to a more personalized approach in the career classes worked for them. The participants felt the instructor in the small groups or one-on-one meetings really understood what the participants wanted and had a sense of how to help them achieve their goals. In these meetings, the participants were also given personalized assignments to complete toward their vocational goals, which many participants stated that they enjoyed. The interesting point here was that although some participants voiced their displeasure with many aspects of the classes, many continued to show up week after week. The participants were in a sense voting with their feet, meaning that they continued to come to class, which signified that some participants found the process valuable. Participants stated that they appreciated for the

most part that the classes were there even though they were not able to attend classes all the time for various reasons including difficulties with symptom management. For example Betty revealed, "I think that one of the things that made it difficult for me to be totally comfortable coming here into the program was a lot of my paranoia. And that got in the way of my coming here, especially on the train and stuff." Ralph also noted that he experienced a high level of stress when he came to the center. Ralph explained, "it's just like, I don't know, I'm kind of afraid that I don't want to get depressed here. I think school made me depressed." Ralph connected that school settings make him depressed and he does not ever want to put himself in a situation that would cause him to experience that level of depression again.

Listening to some of the participants comment here about how they valued the one-on-one meetings, it may be concluded that the participants did not want to have classes at all. Yet, many participants mentioned that they needed the structure and connection of weekly classes. This point was particularly apparent in the section on the importance of supportive places in the third section of this chapter. The participants explained that it was important for them to know that the classes were at the same time and location every week for consistency, connection and dependability. The participants expressed that they also appreciated that someone would acknowledge that they were not in class by calling to check in. In the beginning of the program, many participants revealed that the pressure of individual mentor meetings was stressful for them and it was easier to just come to a group setting like a class to warm up to other participants slowly. Showing up for class was not as challenging as a one-on-one meeting. For example, Betty explained that in career class you could just sit there if

you needed to and not participate but she felt it was progress to be there. Betty disclosed that at least she would not be at home totally isolated which was what many of the participants' stated they did before the program. Yet once the participants felt safe, the transition to some individual meetings worked really well for them.

Another useful strategy of the second theme of situated learning was to tap into the learning potential of participants by drawing upon their past experiences or create experiences that they can relate to as points of reference in learning how to act in future situations. For example, Debbie, one of the career instructors, had the idea to use music to try to connect to the participants and make the class more interesting. During one career class the song, "I Can" by the rap singer Nas was played. Debbie put the song on the computer screen for the participants and they stood along listening and for some singing and swaying to the inspirational lyrics. The refrain of the song was "I know I can, I know I can, be what I want to be, be what I want to be." After the song finished the participants and staff talked about what they wanted to be, what their dreams were, and how they felt equipped or not equipped to achieve them. The participants stated that this was a very powerful class because they felt that the instructors were really trying to understand who they were and what they wanted out of life.

In another career class, the participants were encouraged to bring in examples of things that were relevant to their career paths. One of the participants wanted to be a rapper, so he brought in a tape of his songs and the instructors played a few songs in class. The other participants talked about his lyrics and gave him a lot of positive support and what he felt was helpful feedback about his music. Some participants revealed that it was a bonding moment for the participants and staff to sit and listen to

the participants' music and share in his vocational aspirations in such a concrete and personal way. The participant later noted that he appreciated the opportunity to share the songs he wrote and recorded with his fellow classmates. Many participants remarked that the responsiveness of staff to participants' needs and suggestions for changes in the program was a huge asset of the program. The participants reported that the level of personal attention that they received from the staff, in terms of acknowledging them as individuals, listening to their concerns, assisting them with their goals, calling them when they weren't present, supporting them through difficult times and welcoming them back warmly after extended absences made a real impact on them.

These participants' quotes and these examples of the success and learning opportunities of situated learning amplify and reemphasize Dewey's earlier quote "Education is not preparation for life. Education is life itself." These participants learn best when they are interested in and excited about what they are doing. Miranda, David, Ralph and Rudy are in four completely different contexts but are all experiencing a new level of awareness and growth. These participants reached a new understanding of what they were capable of and what was essential in their own development and recovery. These are invaluable insights that took place in interactive learning situations that are vital to participants' recoveries. In contrast, David, Cyril, Jennifer and Mark agreed that they were frustrated because they were not in the ideal context of being exposed to or supported enough to reach their goals. David, Cyril, Jennifer and Mark all wanted to be in a learning environment with more specific and personalized one-on-one help finding a job.

Community, social, classroom, internship and job experiences are all important parts in the participants' development and vocational recovery provided the participant is within the range of his or her interests, skills and abilities. These challenging yet supportive settings encourage participants to try out various situations and experiences to help them decide where their interests, skills and abilities meet. It is essential to the participants' development and vocational recovery to be able to explore their many strengths and talents before deciding on the situation that may be right for them. The research states that young adults with severe psychiatric disabilities need more access to career opportunities in supportive learning environments that stimulate their interests and their intellect (Vander Stoep, 1999). In fact, many young adults with psychiatric disabilities have impairments in the cognitive processing of forethought, planning, and risk assessment, which further hinder their attempt to transition into adult roles (Davis & Vander Stoep, 1997). Therefore, these participants need to be exposed to lots of different experiences in ways that stimulate their interests and intellect in a hands-on experiential and accessible way.

Theme Three: Taking Positive Steps Toward Recovery

Participants consistently refer to the importance of taking a "positive step" or using Jump Start or an experience related to Jump Start as a "stepping stone". Many participants stated that Jump Start was a safe place to learn and to practice new skills in a safe and supportive environment. The participants were better prepared to confront new opportunities in their lives with a little more confidence, competence and an enhanced sense of hope. Positive steps forward created momentum that the participants

stated assisted them in achieving their vocational goals. For example, Janet explained, "I think the whole experience of Jump Start was probably a moving stone...stepping stone...forwards, not behind. It definitely was a positive thing, and not a negative thing. Especially the mentoring, and like I said before, it's giving me something to do, like structure and having the communication with the students and the teachers." Janet remarked that the Jump Start program connected her with a lot of "...very accomplished different people...mainly my mentor, Stacey". For Janet, Stacey was truly a peer role model whom Janet admired and respected. Janet expressed that Stacey "introduced me to the engineering program and she's still there. She lets me rely on her if I need help and I guess if I hadn't come here then I wouldn't have found out about the engineering program. I guess this started my schooling mainly in a positive step". Janet cited her transition "out of the main part of the Jump Start program and into a positive future." In a sense, Janet was saying that Jump Start connected her to a variety of supports that allowed her to be successful in her field of choice. Janet revealed that Stacey was an important part of her continued progress in the engineering training program.

Betty agreed with Janet and declared that the program "did give me good training for getting back into school [college], you know, beginning stepping ground, definitely good beginning stepping ground." In her quotes, Betty continually talked about how the mentoring had positively influenced her recovery journey. In contrast, Nancy viewed not Jump Start, but her diploma as a critical step toward her vocational goals. Nancy explained, "Before I used to look at these jobs and thought that I couldn't do them because they all required a high school diploma, or more. But now that I have that, that's one step. Most of them require a B.A. or this and that. I'll get there when I

get there." Nancy stated that this crucial first step gave her the confidence to take the next step she needed to accomplish her career goal. For Nancy, this first forward move gave her the ability to see farther into the future and plan in a hopeful way for her future.

Preparing to complete his first step, Tom reported, "I need to take a basic statistics course and the engineering course was one step above it so I have to take the basic statistics course before I take anything about engineering, like a stepping stone." In this quote, Tom expressed his need to have a positive transitional step toward his goal that would both bring him closer to his dream of being an engineer and at the same time help convince himself that it was possible.

Jim declared that he would rather be anywhere than where he was last year, meaning he did not want to be static in his level of growth and potential. Similar to many other participants, Jim wanted to be moving ahead in life. Jim revealed that he was angry "because I don't feel that I have accomplished what I set forth to do" and expressed that he had a lot of career aspirations and that he really needed to work hard to achieve them. Jim was angry that he had not reached the goals that he set for himself three or four years ago. In his words, he stated, "and to this day, only a few of them have been achieved." Jim continued, " Now here I am, it's going on four, maybe even five [years] that I've been out of school and nothing has changed." Jim pointed to the fact that he came to this program to meet his goals, but that the program was not working with him in the way he wanted to achieve his career aspirations. Jim often left the program for a few weeks or a month or two at a time. The participants remarked that they valued the program's open door policy, which was that any participant could

reenter at any time as long as they are not a danger to themselves or to any other participants in the program. The last time Jim sought to return, he had been released from his mental health care provider for not complying with his outpatient treatment team. Jim expressed that he felt the program was not working with him toward his recovery so he was glad to no longer have to deal with them. Jim wanted to be situated in a learning environment that would explain all the steps along the way, that would take him exactly where he wanted to go. Jim essentially stated that if the program did not want to work with him on his own terms, he felt the program was not useful enough to him or worth the time, energy and investment for him. Jim was desperate to find a supportive place that would help him on his way to take positive steps.

Participants stated that the transitional pieces with lots of support helped them to see that their goals were not only possible but truly attainable. For Betty and Janet, as well as many other Jump Start participants, the program, education, and work were all positive steps toward a more hopeful vocational recovery. Completing positive steps in the recovery process is essential to the development and vocational recovery of the participants. On the other hand, participants like Jim felt lost, frustrated and confused when they were not able to progress in a concrete way toward their self-articulated goals. Participants stated that if they don't feel that they are progressing or growing, they feel as if they are back-sliding. If the participants do not feel that they are taking positive, concrete steps in work or in life, they feel that they are out of step with their peers and the rest of society, which they attribute to their psychiatric disability. This can cause participants to experience guilt and shame, which then can produce a downward spiral because they blame themselves for not keeping up with their peers.

Therefore, in the development and vocational recovery of the participants, it is essential to have flexible and concrete support that gives participants access to the opportunity to take specific action steps toward their self-articulated goals.

Summary of Research Question One

Some previous literature stated that many young adults with severe psychiatric disabilities are lazy, unmotivated or unwilling to participate in programs. These participants demonstrate and articulate a completely different picture. Anthony et al. (2002) state that psychiatric rehabilitation has three goals: recovery, community integration, and enhanced quality of life. These participants want all three of these goals and were for the most part anxious and excited to work toward achieving them provided they had the proper support. Everyone needs the appropriate level of guidance and support to be successful, from the doctoral student working on her dissertation looking for guidance on her paper, to the astronaut in flight training preparing for a mission in space, to the woman in childbirth classes preparing to have a healthy baby.

Shontz (1978) was central in developing this concept of appropriate levels of support when he questioned the concept of motivation building on Wrights' earlier works. Shontz (1978) determined that clients were not actually unmotivated, which is defined as a lack of willingness or energy (either emotional, physical or both) to maximize opportunities. He believed that clients were blocked or misdirected in the pursuit of their goals. This is the foundation for the term "readiness" that is used in psychiatric rehabilitation. The term readiness means that clients must have the proper information and skills in order to take advantage of the situation of their choosing. The

participants stated that the Jump Start program as well as several other supports and experiences in their lives increased their readiness to move forward and make positive changes in their lives.

Shontz maintained that the results of an individual's success were not limited by the individual's personal traits or disabilities but by the ability to adapt the environment to the individual, which is a central tenet of psychiatric rehabilitation. The individual has unlimited potential if given the appropriate supports and environmental match to develop his or her existing competencies. Carkhuff (1972) believes in "action orientation" in which the client decides on a plan of action and then follows through on the decided behaviors. Upholding that action orientation is crucial to counseling effectiveness, Carkhuff (1972) states that defining goals and taking action steps toward them is as important as gaining greater insight into one's situation, whereas Rogers (1959) believed that during the therapy session the interaction between the client and therapist led to greater understanding and progress. In contrast, Carkhuff (1972) believes that this newly developed understanding is important, but only if it is used to facilitate action. He wanted his clients not only to reflect upon their feelings, but to use the insights they achieved to take action toward improvements in their lives. The participants strongly agreed with Carkhuff; they wanted to take actions toward creating a better life for themselves. Carkhuff agreed with Wolpe (1966) that behavior was a product of learning. Maintaining that behavior is altered through active participation in learning experiences, Wolpe (1966) stated that eliminating one's maladaptive behaviors and learning more effective behavior patterns could change present behavior. Carkhuff integrated the humanistic theories of Rogers (1959) with the behavioral theories of

Wolpe (1966) and established himself as a significant figure in psychiatric rehabilitation (Anthony et al., 2002). Truax elucidated the concept of "teaching as treatment," an in-depth theory of rehabilitation (Carkhuff & Berenson, 1981). Carkhuff (1967) and Truax (1967) conducted a direct form of "teaching as treatment" in which the client is personally trained by the therapist in the skills in which he or she needs to function effectively.

These concepts are closely related to situated learning that built the foundation of the parts of the program, which the participants reacted to favorably. For example, Richard stated, "I ain't got time to just sit around and talk about it. I just got to do it." Jim echoed Richard's statement by saying, I can't be "sitting around listening to practice." they both wanted to be involved and running the process of their own recovery which is the goal of psychiatric rehabilitation.

Discussion of Research Question Two

Research Question Two: What are participants' experiences interacting with supports in their development and vocational recovery? The second research question is what are participants experiences interacting with supports in their development and vocational recovery. The five themes that emerged from the participants were (T4) Participants needed opportunities and places for safe transitions; (T5) Participants respected the role of professional support in their lives; (T6) Participants struggled with the role of family in their lives; (T7) Participants welcomed the role of staff support in their lives; and (T8) Participants valued peer support in their lives. Under this section, the participants' interaction with supports took many forms. The participants'

interaction with various types of support is discussed below. Interaction with supports can take many forms; as people, places, or things. Professional, family, peer and place support have all been critical in the development and vocational recovery of the participants. These can manifest in different ways through a psychiatric hospital, a participants' home or work, a vocational program, a mentor, and/or the participants family.

Theme Four: Supportive Place

For some participants, like Sam, the psychiatric hospital was a place of security and safety for her recovery to take place. Sam acknowledged the importance of theme number four when she talked about the importance of the supportive place in her life. Sam stated, "being here is better than that other psychiatric hospital. I can go to the cafeteria and I have cable. It's nice here. I love it, (pause) not love it, but I don't want to get too comfortable." Sam stated that the atmosphere in "the new hospital is supportive. There are lots of people on my treatment team." Sam felt comfortable in her new setting with both her treatment team and the physical surroundings. Sam confirmed that this was a supportive place for her to continue her development and vocational recovery.

Work was also a place of vocational recovery for some participants. Jennifer, who dropped out of Jump Start early on, stated her work was instrumental in her development and vocational recovery. Jennifer declared, "I have a job now. That has been very helpful." She stated that she has "the nicest boss I've ever had" and who treats her "like an equal, which is really important and I just love everybody I work

with." Jennifer explained the fact that her boss and co-workers respect her and she gets along well with them was an extremely important source of support for her. Jennifer confirmed that this positive interaction was even more important to her than money, when she stated, "I don't get paid top dollar, but I don't mind because the people are just so much more with it."

Tom agreed with Jennifer, on the importance of theme number four, support place. For him his workplace was also a critical part of his vocational recovery. Tom remarked, "I've been working. I guess it's just going back into the business field." Tom expressed that he felt better while working, "the environment is making me happier and the fact that I'm getting paid, not just a volunteer thing." When Tom explained that the money was important to him, he acknowledged, "I guess I'd have to say it's the paycheck and interacting with customers. I like that." Tom commented that he also liked being situated in a productive environment when he stated, "And the fact that I'm working, and not sitting there at home, eating chips and watching TV that doesn't interest me."

Rehabilitation and a vocational program can also be a supportive space for participants in their recovery. Nancy found that in a program that saw her through the difficult times, and remains a place to check in with, to gather support from and still acts as a marker to guide her in her recovery process. Betty discovered the Jump Start program classes "for what they were I think they helped in the aspect that where I was in my life, I had a place to come to that was familiar. It provided structure, which was really important. It got me out of Hopkinton." Betty stated that the classes provided her with the structure and security she needed to take the next step and connect to the

outside world. Debbie felt it was the "connectedness" and learning "how to be in one setting and be one person and be in another setting and be another person. Sort of like different sides when you are supposed to show them." Debbie expressed that she appreciated being able to try out her social skills in a positive way. Debbie continued "that there was a way to express yourself and your opinions and at the same time it is not threatening." Missy declared "it was the church because I went and got baptized in July and got a certificate for it and everything" that made her feel safe. Missy's place of safety and security was the church where she felt respected and loved.

Theme Five: Professional Support

Some participants stated that professional support has provided them a greater capacity to cope with and move beyond their disability. Several participants stated that professional support was important to their development and vocational recovery. In some cases participants stated that psychiatrists were the critical link to recovery by providing the correct dosage of medication that initiated some measurable improvement with less side effects. For example, Ralph stated, "they've been starting to give me an antidepressant and I don't know, I guess there's like a noticeable difference." Sometimes it was the psychologist or therapist who listened to the participant and helped him or her better understand themselves or their experiences. For example, Wanda explained that she was working with a therapist on "different techniques and stuff" so "that I can deal with issues in my life more easier and stuff like that." Wanda affirmed that it was her therapist who provided her with the supportive guidance to help reach that important level of self-awareness into the way she expresses emotions and

communicates. Some participants, like Erick, acknowledged that "my psychiatrist, Dr. Marian, is very helpful. I just get to talk to him about my day to day problems and things I'm concerned with and that helps." Erick explained that he valued being able to share and discuss his everyday situations with his psychiatrist. Sam shared, "a doctor came by yesterday and said I am doing good work, we have faith in you, keep doing what you are doing. I have lots of encouragement. I also have Dr. Killroy (her psychiatrist) who says if I'm doing a good job then I can leave the hospital and go to a partial program." This statement articulated how much Sam valued the staff doctors at the psychiatric hospital and her psychiatrists' positive encouragement and feedback on her progress. Sam disclosed that this has been critical to her progress in the hospital as well as her mentors' daily phone calls and consistent support. Definitively, many participants expressed the value of professional supports in their development and vocational recovery.

Theme Six: Family Support

Many participants stated that family support was an important part of their development and vocational recovery that either fostered or thwarted their recovery process. Parents, grandparents, brothers, sisters, guardians, and significant others of the mother or father, both through their presence and sometimes more powerfully in their absence, were sources of support, encouragement, hope, frustration, anxiety, and fear. Several of the participants struggled with the challenge of autonomy and connectedness with their family as they tried to establish their own identity while attempting not to pull too far away from a source of support. Betty was an example of this complicated

struggle when she explained, "Now, looking back at how I connected myself with my parents, now the next step for me is trying to get away from my parents, in a healthy way, by moving out of the house because I'm 25 years old and I shouldn't be living with my parents the rest of my life." Steve stated that it was his "family most of all. They pushed me the hardest." Steve stated:

> I have a way of doing stuff for a little while and then saying I don't like it. Somedays, it was fun, but sometimes it was just to get attention. I just told my friends and parents that I wanted to drop it, but they wouldn't let me, they said it would pay off in the end. Like I'm going to school and getting my life on track, stuff like that. They don't want me to quit.

In a similar but more tension filled relationship with his family, Jim declared,

> My friend wants to sell me his car for $400.00 but my family thinks that is a big mistake. Of course, anything that involves me getting something to complicate my life a little bit more my family does not think is a good idea. I can't have a girlfriend. The only thing that they want me to have that would complicate my life a little bit more is a job or school and they don't mind me having that because it complicates my life in a good way, but a girlfriend or a car really they don't think is a necessity.

Jim explained that he and his family do not exactly agree on what is important right now as priorities in his life. Jim wanted a girlfriend, a car, further schooling and/or a job. Jim believed his family thought a girlfriend and a car were unnecessary distractions to what they believed were his main objectives. In contrast, Jim viewed a girlfriend and a car as crucial necessities in his life. As a result of this disconnect, Jim often experienced tension with his grandfather and would not go home for days or even weeks at a time.

Kara expressed that her dad, although he doesn't fully understand the depression, has been supportive in his own way. Kara explained that her dog has been a great source of comfort and support in her life. Kara stressed that her dog, Muffy has

gotten her through some very lonely and sad times. For example, Kara stated, "when I was crying over my grandfather and my uncle's death, Muffy, would come in the room and lick my face and I would lay there and bury my face in her fur and she was very helpful because she lays with me and I feel safe with her." Muffy has been an important sense of hope and connection through the deaths of her loved ones. Kara stated that Muffy makes her "feel safe" because she was always there and provides a constant level of positive companionship. The dog's love was supportive and unwavering, which was a crucial emotional support for Kara. Aside from her dog, and the support of her dad, Kara did not have a lot of other supports that she could depend on.

Other participants had very complicated and painful relationships with their family. Several participants were sexual and physical trauma survivors by members of their own nuclear or extended family. As a result of these actions, participants stated that they felt angry, confused, used and worthless. Some participants turned their violence inward in the form of an eating disorder or cutting one's body while other participants' lash out at others because they can't express or control the intense emotions that these events have caused. Participants continually struggled to get to a place with their family in which they felt supported and understood; not controlled, abused or disconnected. Therefore participants stated that family support, family neglect or continued family psychological abuse was a critical factor in their development and vocational recovery.

Theme Seven: Staff Support

Several participants' relationship to the staff and their connection to the program was important to the development and vocational recovery of the young adults. Some participants had challenging relationships with staff or were not able to form any connections with the staff at all. Participants were asked to contribute to their own personal development through their individual meetings with staff where they would define and follow through on their goals. Many participants noted that theme seven was an important part of their recovery processes. Several participants explained that having someone to connect to and rely on in a professional capacity was essential to their recovery journey. A few participants were not interested in the classes or the mentoring relationship but really valued and relied upon their connections to staff. A couple participants liked to meet with staff instead of going to class. Some participants would have liked all individual meetings with staff and no participant or mentor interaction. In fact, Richard's primary contact with the program was the staff, which will be explained further in the mentoring section. Richard stated:

> What I've gotten out of this program had nothing to do with the classes. Derek (a Tai Chi instructor) was really down to earth, I really liked him. He seemed genuine. And then there is you (Co-manager of Jump Start, Sasha). I really didn't trust or care about anybody else.

Miranda also preferred meeting with staff but for very different reasons. Miranda desperately wanted to connect with the other participants but she had difficultly connecting with peers her own age. In fact, Miranda often showed up at the center during the time of the GED class but took that time to visit with staff instead. Eventually, an email had to be sent out to staff stating that during the hours of GED class, please do not allow Miranda to meet with the staff. The staff was asked instead to

redirect her to GED class and remind her of her desire to obtain a GED, which she talked about constantly.

The relationship between staff and participants in the classes was an important example of person-centered services in practice, but it was especially apparent in the GED classes. At first, the program hired mentors as tutors in addition to some of the staff. Attendance was sporadic so each participant that showed up worked with the tutors on that particular day. Who the participants were matched with varied week by week, and attendance got worse. Miranda declared that she and other participants wanted the same tutor every week. Miranda explained that she and the other participants wanted a tutor who knew their specific level of skill in each area and how to help each participant progress on a weekly basis. Therefore, Miranda was instrumental in solving the attendance problem. Miranda expressed that helping to change the structure of the class gave her a feeling of importance and satisfaction. Miranda confirmed that she believed the staff wanted her to succeed because they made the changes that she felt was important for her success. Miranda stated that she really enjoyed meeting with her tutor, Matt, every week and being personally coached to succeed with her GED plans. Cyril agreed with Miranda, when he stated:

> I like the GED classes. I like being around people. I want to work one-on –one with someone. I want someone to work with me; like writing a paper every time, maybe about my mental health. I feel way behind. I'm feeling trapped. I can't think. I can't focus. I see this place as a place of opportunity but I don't have the same ideas as somebody else. I don't have any idea about what's happening to me.

Cyril, like many other participants, wanted someone to care about the progress they were making, someone who would be there to help strategize, and someone to increase progress or work to improve things that weren't going as well. In general, the

participants just wanted someone with whom they could personally connect. Frank shared that in the GED classes, "Sasha (co-manager Jump Start/instructor) and Stacey (GED tutor and mentor) were particularly helpful because "they read real slow and helped me understand it. Then, I read it myself slowly." Frank explained that these instructors supported him in his learning efforts by first modeling the behavior and then giving him a chance to practice what he had been shown. This type of modeling was an example of Bandura's (1977) social learning theory. This model defined the five learning steps an individual goes through when attempting to learn a new skill. The first of Bandura's (1977) five steps was that the individual was taught the skill as a didactic process. The next was modeling, in which the individual watched the instructor perform the skill. Sasha and Stacey were modeling the specific skill, i.e; that they wanted Frank to learn. The third step was role play where the individual role-plays or acts out the situations and skills in question. In GED class, the participants were often asked to go to the board to explain newly learned skills to the class. The fourth step was behavioral rehearsal in which the individual carries out the skill. This step takes place when the participants complete their homework to reinforce the skills they have learned in class. The final step is a realistic work-practice, in which the individual practices doing the skill in the real situation. This step took place when the participants took the practice tests in a timed situation that is similar to the real testing environment. Each skill progressively builds on the previously acquired skill so that the skills or behaviors are gradually learned. After each participant was individually assessed for their skills and matched with the same tutor week after week, the participant attendance and progress greatly increased. Please see Appendix C for a more detailed explanation

of this change. This process of social learning was used in GED classes but it was also used in the mentoring relationship, which will be explained further in the mentoring section.

In agreement with Miranda and Cyril, Erick explained that Jaffray (an instructor) "talked to me about potential for me to get internships and just in general I like talking to her. She's an artist and I admired her." Erick explained that Jaffray was "very, very helpful" and a "good influence, maybe a little more positive about things." Erick's perspective was consistent with the research that stated that young adults with severe psychiatric disabilities often need assistance in reframing their perspective into a more optimistic broader view because they tend to be hard on themselves and pessimistic about their level of skills and their future (Vander Stoep, 1999).

Similarly to Erick, Sam expressed that the staff was a very important part of her experience at the center too. Sam explained, "Donna (an instructor and job developer) made an impact. Lori (an instructor) made an impact. The whole staff talked to everybody, which was good. You all helped me in different ways and I really appreciate that." Even when Sam was committed to an inpatient unit at the hospital, several staff called her frequently and supported her over the phone. William also felt supported by the staff. William stated that Debbie (instructor) and Kim (Co-manager of Jump Start/instructor) and Lori (instructor) all were helpful in achieving his career goals. William went on the explain how they assisted him in his career goals, when he stated:

> They always listened. They gave me good advice. They did a good job teaching the class. They did a good job about going into detail. Not leaving too much uncovered. Debbie was out a lot, a lot more than I wanted her to be. But I was out a lot too, so I can't talk. Pretty much all

> the staff that I have encountered have been sufficient during my stay at Jump Start.

William then talked about a specific example of a concrete career step that he achieved with the help of Lori (an instructor). William detailed out his experience on his first informational interview in his field of choice. William explained:

> Lori hooked me up with a record producer friend of hers who used to live in New York who's not into hip hop but he's into music. He did an informational interview with me at his recording studio. An informational interview, where he gave me some very, very good advice. About how there is more to music than being just a record producer. You can do things behind the scenes too. That was basically what that conversation was about. He's in another field of music so he didn't help me get anywhere but he helped me as far as things I needed to know.

William, like many other participants, appreciated and valued the one-on-one support provided by the staff, especially when it involved a tangible activity like working on a resume, getting an informational interview, listening to a problem or acknowledging and following through on a participants suggestion for changes in a program. Many participants stated that they felt understood and cared about by staff. In contrast, some participants' did not connect with any staff and felt disconnected to that level of the program. Some participants like Richard only connected to one or two staff, and did not like any of the other staff. In contrast, Miranda connected to some staff particularly strongly but basically would interact with any staff who had the time, energy and inclination to show her support and encouragement. Therefore, participants felt that staff support and connection or lack thereof was a pivotal point of entry and continued attendance and success at the program.

Theme Eight: Peer Support

The eighth theme of peer support has been a critical element in the development and vocational recovery of the participants. Many participants stated that it was very difficult for participants to create and sustain friendships after they received a diagnosis or had a psychotic break. Many of their friends have moved away to college or cannot relate or connect to the participant in the way he or she used to. Many participants have severe anxiety and tend to isolate themselves a lot. Others have internalized a lot of social stigma and have difficulty interacting with others.

Alison was an example where peer support has been a pivotal source of support and encouragement. Alison was talking about her level of personal support and connection she received from her peers at the center. Alison explained that she was able to connect with them in a way she has not been able to with her other friends because, like the mentors, her peers possess a level of understanding from a place of experience not just from knowledge. Alison noted that she really appreciates the fact that she expanded "her circle of friends" with an "exceptional group of friends, because we have a connection that is unique, that most people don't understand. The participants sought a sense of connection and positive reassurance from one another. Participants wanted to know that that they were not alone in their experiences and that this was not, as Alison stated, a "unique illness." Participants struggled for ways to move beyond the fear and insecurity of their psychiatric disability and genuinely connect with others. Alison felt supported by her peers who "encouraged her" and "let her know that thing are ok." Alison confirmed that her peers supported her in the belief that "things will improve in spite of this illness." Alison shared that peer supports were

a critical part of her development and vocational recovery because her friends can relate to her and provide her hope in real and satisfying ways. Alison also had a very positive experience with creating friendships in Jump Start. She explained,

> Ya, I've definitely gotten friendships out of this program. I have really enjoyed being able to connect with people. I thought it might be temporary just to share you know, a similar mental illness and to just to be a support to each other. You know, to not feel that we are alone or different.

Alison expressed that she has done things outside of the program with participants too like "go to the movies, out to dinner". There was a tremendous range of experiences of peer support both within Jump Start and outside the program as well. For some participants the experience of peer support in Jump Start was positive. For example, Tom stated, "I formed a relationship with Jim and Ralph; and with Susy, from the other program. She's a good friend too."

Jim explained that peer supports were not a critical part of his recovery process. Yet Alison and Miranda viewed the development of peer supports as critical to their recovery. Jim explained his interaction and how he related to his peers in the program, "students do different things. Some are cool as sh**, and some I just don't talk to." Jim stated that he really liked some participants and then did not really bother with others. Jim stated, "in fact, there is only one person here who I really don't like and I don't even know his name." Ralph stated that he developed a friendship but that he was confused because he felt the connection to his friend has lessened. Ralph shared,

> Yeah, I don't know, the first week or so I kind of made friends with Jim. I don't know, we hung out a while together, he brought his Play Station over and he also dropped his hedghogs off with my parents. I really haven't seen him lately because he didn't really have a house for a while and uh, he, I don't know, he seems like he's been avoiding me lately but … uh, I don't know.

Ralph did state that he enjoyed the connection of being out of his house. He enjoyed being social with the other participants' when he was in the right state of mind and could control his symptoms. Ralph commented, "I like playing pool with my friends. It feels more comfortable."

Steve's experience with the other participants was neutral. Steve expressed in earlier quotes that he had a lot of support from his family and friends outside of Jump Start (see p. 200). This fact may explain why Steve was not interested in spending time with other participants. Steve never attended any social events or made any efforts to form significant relationships with other participants'. Steve stated, "When I come here, I like to talk to them about sports and stuff, but I don't like to hang out, not buddy-buddy. We just hang out here and talk about what we did over the weekend. But we don't ask 'what are you doing Friday."

Amanda expressed that she had difficulty with connecting to the other participants. She explained, "I tend to have problems with social skills, especially when I reach out." Amanda continued, "I personally tend to isolate myself and didn't expect myself to go outside my circle. I have certain kinds of tendencies." In these statements, Amanda revealed her pattern of isolating herself in social situations due to the anxiety she experiences. Amanda connected very well with her mentor and got along well with a few staff, but peer relationships were particularly hard for her. Therefore, the program was not helpful in terms of developing Amanda's peer support network.

Although Amanda had difficulty connecting with other participants, at times she tried to attend social events and interact with other participants' after class. Cyril also

had tremendous difficulty connecting to other participants. Cyril was often actively psychotic in class because he refused to take his medication. Cyril explained,

> I like being around people. It was difficult to communicate when I couldn't understand the words coming out of people's mouths. I like getting along with people, and like the computers. I connected with one other student but I forgot his name. He was about 17 or 18 and he had a job. I feel very alone. I have friends but I can't get through to them.

In contrast, Richard was strongly against developing friendships with other participants. Richard put forth no interest or energy in getting to know any other Jump Start participants'. Richard felt he was better than the other participants' and that his time would be better spent cultivating friendships with people who were already better off than he was. Richard remarked in a very matter of fact way, "I have made no relations of value with other Jump Start folks. Most of the people here are in worse shape than me and I hang out with people who are better than me." Richard went as far to say that he only cared about two staff, Derek and Sasha, "I really didn't trust or care about anybody else."

Peer support was a critical issue for participants' and whether the participants successfully cultivated friendships inside or outside of the program, the topic of these friendships or lack thereof were of critical concern to the participants. Alison told us she was able to develop strong friendships inside as well as outside the program. Miranda informed the staff that her main focus was to learn how to have regular, non-clinical relationships, especially with peers. Tom made a few friendships, which he valued in the program. Jim connected with a few participants in the program and didn't connect with others. Ralph struggled to develop and maintain friendships in the program, but in general appreciated the opportunities to be social with his peers, which

in the rest of his life were few and far between. Steve valued his supports outside the program so he made no effort to further develop his relationships. Amanda found it challenging to connect with her peers even though she understood it was a valuable thing. Richard had no interest in developing any peer connections through Jump Start. All of the participants were actively seeking peers who they could relate to, connect with, and respect but there was tremendous variation on who, when, where and to what degree they sought these relationships. Clearly, peer support was a central issue for participants in their development and vocational recovery.

Summary of Research Question Two

Interaction with supports can take many forms: people, places, and/or things. Professional, family, peer and place support have all been critical in the development and vocational recovery of the participants. These can manifest in different ways through a psychiatric hospital, work, and family. The participant's stated they greatly appreciated the flexibility of the program and the access to the varying levels of support. Several participants stated that having the flexibility of the four levels of participation, the mentor meetings, the classes, the individual meetings with staff and the social and community activities really helped them to stay connected because they felt their choices and preference were heard and respected.

The goal of psychiatric rehabilitation is not to make everyone the same, but to enable individuals to develop their own capacities and skills. Providing support with environmental specificity is crucial because individuals behave differently in varying environments. Psychiatric rehabilitation emphasizes assessing individuals in specific

relationship to the demands of their chosen environments (Anthony et al., 2002). Helping individuals to improve their role capacity in a particular living, learning, working, and/or social environment is central to the mission of psychiatric rehabilitation. This outcome is achieved through behavioral modification interventions that use modeling and activity to guide the individual's development, rather than verbal therapy (Anthony et al., 2002).

Supportive relationships are important to further their ability to successfully navigate life's challenges (Kastner & Wyatt, 1997). In the current system there is no provision of adequate supports to prepare these young adults to transition to adulthood and even fewer resources that put the individual relationships at the forefront of participants recovery. Therefore, young adults are left to face adulthood with a myriad of skills deficits that all to often result in a downward spiral of poverty, crime and chemical and system dependence before many more young adult lives are prevented from developing their educational and vocational competencies.

Discussion of Research Question Three

Research Question Three: What were the participants and mentors experiences with the mentoring relationship in their vocational development and recovery? .The third research questions, what were the participants and mentors experiences with the mentoring relationship in their vocational development and recovery, has one central component of the ninth theme, which is the importance of peer role models as mentors.

There were many critical factors that led to a successful mentor and participant relationship. Many participants stressed the importance of the mentor maintaining

steady and reliable communication patterns. The participants also stated that the initial connection and relationship building phase was essential to the success of the match. Expressing that an initial connection and admiration had to be present for the participant to want to make the effort of getting to know the mentor. Throughout the trainings, the mentors were frequently reminded that they needed to be the ones to reach out to the participants. The mentors were instructed to take more initiative in setting up times to meet the participants, especially in the beginning of the relationship. The mentors were asked to make more calls to their participants and to follow up with reminders of when and where the two were going to meet. In the relationships that worked best, the participant wanted to learn from or be more like the mentor. If the mentor had a personality trait such as being outgoing or friendly that the participant admired or wanted to develop within him or herself or if the mentor had information or experience in something that was of interest to the participant like art, music, education, engineering, or career development then those relationships were more likely to flourish.

Many participants shared that they were angry, hurt or disappointed when a mentoring relationship was not able to be formed or the connection was not able to be sustained; the participant often felt guilty, disconnected or angry as a result. The reasons for the disconnect were varied. Geographic location was also a big factor in the relationship because of transportation. For example, Kara stated that one of the reasons she dropped out of the program was because her "family has moved to the boonies. So, good luck to me on that one. Pretty dark and quiet. I live in a suburban neighborhood." Many participants did not have their own car or access to a car. In order to meet up

with their mentor some participants spent a long time on the "T" or had to involve their parents in the process. Some mentors had cars and often picked up and dropped off participants at their houses or at more central locations so that the meetings would not be as challenging for participants'. Many participants expressed a lot of difficulty and stress navigating public transportation especially if it was later on in the day or at night. For example, Miranda stated, "the commute. It was scary to get here. Taking the 'T' and seeing all the people. It was the area also. It was sort of like a new part of the city for me. It boosted my self esteem to be able to do it though." To lessen some of the logistical complications many mentors found it was helpful to meet their participant before or after classes at the Center. Some participants, like Ralph who lived farther away, stated that this was a useful strategy for him and his parents because he already planned this activity into his day so it was easier to just add another activity on, rather than create a new activity on a new date and time. For other participants, who did not like coming to the center, like Rudy, this was not a useful strategy so she would meet her mentor and go on activities and trips far away from the center. Rudy stated:

> I've developed a good relationship with my mentor, like friends. We do activities together. We went to different places together. We went to Kennybunkport, Maine together. I don't feel like I shared a lot with her but we were more like activity buddies together. We went to Jillian's (a pool hall) and we went to the mall and we went shopping around Boston and that type of thing.

The mentors stated that their recovery process was positively impacted through assisting the participants in their development and vocational recovery. Most mentors took very seriously the challenge of helping the participants navigate the transition to adulthood. The mentors talked about struggling to understand where the participants were at, and resisting the temptation to "jump in" and solve the participants problem

immediately. The mentors explained how important it was that they be available for the participant and be able to listen and respond to the participants' problems but not to try to solve them. It was a challenge for some of the mentors to act as a good listener, a guide, a sounding board, or an activities friend who was there to just be with the participants and share in the journey. The majority of the mentors stated that they would continue their relationship with their mentee after the program had ended.

Some participants' disliked coming to the program but loved meeting with their mentor every week and talking on the phone with him or her a lot. Other participants really enjoyed going out and doing activities together. For example, David stated:

> Al, my mentor, we did a lot of stuff. Maybe every couple times a month we'd do something. Like went to the Fenway. Got a tour of the Fenway. It was really fun. Like we saw the players' locker room. I had never been in the players' locker room. Then he went over my house once and we played basketball at a local gym. We went to the Boston Billiards with the program too. That was probably the biggest thing that we did. I stayed in contact with him and had pretty good relationship with him. I've never had a mentor before I came here.

David was excited about his relationship with his mentor, Al. David was delighted to be able to go and do new things like go to the Fenway and play pool. Al comments on his relationship with David at the end of the mentoring section. David, like many participants', especially the males, liked physically connecting with their mentors over activities and sports. David stated that what he liked best about the mentoring relationship was "doing stuff." David described playing pool, basketball, softball and going to the gym as activities he really enjoyed doing with his mentor. David stated that going to the Fenway for a tour was also a cool activity. Doing activities together was actually much more preferable than getting together to talk. Most participants, especially the male participants, liked having a set agenda or having

something to do. David liked having an "activity buddy" to use the phrase that Rudy coined in her quotes. David stated that his mentor was not central to his vocational recovery but was someone he valued to hang out and do things with. Many of the participants had difficulty making the effort to stay connected but found it very valuable if they could maintain their connection. For example, David commented on his mentoring relationship, "I like it. It was just a little hard to stay in contact sometimes. You had to call sometimes, and he was busy. It was a different kind of relationship, a little harder. It was fun to do stuff."

The connection and bond established between mentor and participant seemed to be much more important than the actual career or career exploration skills that a mentor had. David stated that Al was not involved in his career development, but they "just basically hung out." Bob agreed with David, when he explained that Carl was not a career mentor but was "just someone to discuss common interests and career interests." Bob was not looking for another job developer or a career coach, he just wanted someone to hang out, talk and do activities with. Like many other participants, Bob enjoyed going to play pool with his mentor and they also went to a ball game. The physical connecting, of going to do things together, like playing pool, or as Miranda shared, "going to the mall." Participants stated that it really helped to take the pressure off the initial getting to know you process when the mentor and participants did activities jointly instead of just talked. Participants and mentors revealed that many initial meeting were stressful, especially given the fact that many of them experience various levels of social anxiety. Yet overall, the mentors' ability to both do activities with the participants as well as be there to listen, share and support the mentee seemed

to be the critical foundation of a successful match between the participant and the mentor.

The mentor relationship was a different experience for Sam because during part of her time in the program she was in a locked unit in a psychiatric hospital. Sam had a complicated year. She started out very strong and was completely invested in the program. After being in the program only a few months, she completed an informational interview at Massachusetts General Hospital with a neurosurgeon because she wanted to be a doctor. The interview went fantastically. Yet shortly thereafter her psychiatric disability caused her problems and her negative thoughts overtook her and she began to act out once again. In the beginning of their relationship, Sam and Mary did a lot of activities together like going out to the movies, going to lunch and going to the mall. Then, Sam was committed to a locked psychiatric unit and her mentor visited her to continue working on her GED. Sam stated that Mary's continued support during this difficult time made a huge impact on her. Sam stated that during this time, her mentor was extremely effective in encouraging her and helping her feel more supported and less isolated. Sam reported:

> My mentor, Mary, has made a good impact. I talked to her everyday you know....Well, Mary encouraged me to do better. She's helping me with the WRAP (Wellness Recovery Action Plan), and was teaching me the. GED. She just gave me a lot of support and when I have a problem or I'm just sad, I call her and she just listens to me and she gives suggestions. It's very helpful.

Like Sam, Betty talked about how much of an impact her mentor made on her life. Betty stated:

> I've gotten to know her very closely in the small amount of time that I've known her. And we've not only done multiple activities together, but we've really grown close. I feel very connected to her. Just the other

> day I was with her and she said that she thinks of me as one of her friends.

Betty remarked that she values her friendship and really enjoyed doing things with Alice. Betty explained, "we'd talk. We'd do walks. I just went to her apartment and hung out. She showed me her artwork and cooked me an omelet. We've gone to the North Shore and walked around all the art galleries." Betty felt that she and Alice were matched very well because that had similar artistic interest. Betty also shared that she felt it was significant that she and Alice shared the same severe psychiatric disability. Betty commented,

> And also the connection that we're both bipolar. I've been able to ask her a lot of questions about living with a mental illness that I haven't been able to ask other people. My friends have no clue or interest or any desire to know about it. My mentor had made an impact to my life, even if I only see her once a week or once every other week

Although many participants expressed their satisfaction and comfort knowing that the mentors understood first hand the pressures and challenges of having a psychiatric disability, Betty was the only one who talked about how she felt it connected her to her mentor in a unique and meaningful way. Many participants' including Betty, noted how important it was to have similar interests in common. Betty expressed:

> When I asked for a mentor, I wrote I want someone who was into art. Yeah, she's a great artist. She's great, very talented. I went to art school for a year and a half and then I dropped out because my illness was kind of getting in the way. So, now I do artwork every once in a while, but really haven't been that motivated.

Betty declared that she was thrilled that her mentor and she shared the same interest, which was art. Betty was surprised that just because she requested that her mentor be someone interested in art that it was able to happen. Participants really

valued when their thoughts, interests, and abilities were taken into consideration in very concrete and specific ways. This mentor match really made an impact on Betty because she felt supported by a program that listened to her preferences. Many times, participants questioned why they had to fill out so much paperwork and so many forms. Participants were wondering if it would matter what they wrote down on the many questionnaires. For participants like Betty, Bob, Janet, Miranda and Amanda they felt like their personal and or career interests were validated through their matches.

Many participants' preferences could not be honored through the match for many reasons. Many times there was not a mentor who matched their career preference or personal interest. For example, Tom wanted a male mentor in his career field and was completely disappointed that a match was not available. Although Tom went out with his mentor a few times, he never felt connected to him. On the other hand, Tom felt very connected and supported by Donna (an instructor) and his job coach. Tom stated that personal comfort level and connection were important to him.

Other times, the mentors were not able to fulfill their mentoring commitments because of circumstances beyond their control. These were day-to-day life challenges that could not have been anticipated. Two mentors had to end their mentoring commitment because their psychiatric disabilities became unmanageable for them. One mentor had a death in the family, one participant changed jobs and a third moved to another state for a better job. An unfortunate example of a failed mentoring match was with Richard. After this experience, Richard was completely frustrated and disillusioned with the idea of mentoring. Richard explained, "my experience with mentors was I hooked up with my first mentor and he lost it. Then I hooked up with a

second mentor and I thought I was further along than he was. I really don't have any faith in this mentoring thing." Richard was referring to the fact that his first mentor had a psychotic break and had to abruptly end his mentoring commitment, which was personally very hard for him. Richard had a positive initial connection to his first mentor Travis. Richard admired Travis as someone who had moved on from his psychiatric disability to have a successful and rewarding career and family. Therefore, when Travis experienced his psychotic break and had to end his mentoring relationship abruptly it unnerved Richard. Richard was then matched with other mentors but he continually stated that they didn't quite "match up". The fact was he was also afraid to get his hopes up and be let down again.

For other participants and mentors, schedules or location meetings did not match up, so that made the relationship not a viable match. For example, Bob and Carl had difficulties meeting as much as they would have liked due to the fact that they lived very far away from one another. That was one of the most challenging parts of the program, to attempt to reconcile the expectations of the participants when the mentors were not able to meet their commitments to the participants. One mentor in particular was matched with three participants who connected very well with him and then were very disheartened and mad when his own psychiatric symptoms made it impossible to continue. One participant of this mentor, named Dan, dropped out immediately from the program after his mentor left and never reconnected. The second participant, Jim, refused to be matched with another mentor and remained distant almost untrusting of the program after that. The third participant, Richard, refused every other mentor offered to him because they did not "match up" to the initial mentor.

Summary of Research Question Three

Numerous participants stated that the existence and strength of the mentor connection was extremely important to them. Most participants stated that the mentor match was the most important factor in whether or not the participant stayed with the program and it also impacted their level of participation in the program. The saying "showing up is 99% of the job" applies here. However, several participants who were not able to create or maintain a meaningful connection to a mentor felt disconnected, angry or chose to withdraw from the program. Some participants never quite rebounded after a poor mentor match and would not allow themselves to fully participate in the program because they did not want to open themselves up to hurt and disappointments any further.

These comments speak to the participants' remarks that the most essential part of mentoring was consistently showing up. The second most critical factor was that the mentor must contact the student frequently, especially in the beginning and ideally weekly. If the mentor cannot meet in person, then he or she should be in contact either over the phone or via email at least every other week. Thirdly, the mentor must interact with the participant doing activities that they both enjoy, such as going to the movies, going to an art show, or going to play pool. Please see Appendix C for a more extensive list of participant activities. The participants expressed that it was not essential that the mentor be a career coach or be helpful with the job search, although several were helpful in those areas. What was really significant to the participants was having a supportive role model who cared about them enough to listen and share their lives in a non-judgmental and supportive way.

Some mentors were a critical piece of the participants' successful transition into adulthood and adult roles and also for hopefully planning a better future. The rate of participation of the participants was a significant achievement in and of itself because the dropout rates for these participants are extremely high (Vander Stoep, 1999). The continued level of interaction of the participants was attributed to many factors. The first reason was that many of the participants interacted with their mentors largely outside of the program in locations, situations and activities that the participants and mentors agreed upon. The fact that the mentors also experienced severe psychiatric disabilities and were able to relate to the participants from a genuine place of knowing what they were experiencing was also an essential component of the participants' connection to the program. Since these young adults were in the process of trying to understand themselves and the impact on their psychiatric disability it was very helpful for them to relate to someone who has 'been there' and moved through it.

Several participants reported that the mentors listened, counseled and helped them understand their experiences and assisted them with the actions or steps they would like to take to either improve upon or rectify their situations. Many participants' reported that they had difficulty maintaining an optimistic outlook on their future especially when their symptoms were flaring up or when things were not going well in their lives. Therefore, the participants' remarked that they appreciated having the support of a mentor who they could reality test with who could help them keep things in perspective. Research by Vander Stoep (1994) documented that young adults experiencing severe psychiatric disabilities need perspective-taking skills and need to be able to help reframe situations in more constructive and positive ways. The mentors

remarked that they really enjoyed working with the participants and being able to facilitate that process and to fulfill that role.

The flexibility of the involvement in the program was also a big reason for participant retention. Some participants did not feel their mentors were the "right match" for them, so they switched to a new mentor. Some participants' did not want a mentor so it was not required. Other participants did not/could not come to classes because of other commitments, so they chose to only interact with the mentors or with a particular staff for whom they had developed an affinity.

Summary of the Qualitative Research

Many participants remarked that it was the combination of the three core concepts of the research questions that impacted their development and vocational recovery. The first research question, situated learning, involved specific and concrete activities in an environment that was personally relevant to the participant. The second research question, interaction with supports, involved both assistance and growth opportunities. The third research question focused on the interaction of the mentoring relationships that had a significant impact in the lives of both the participants and the mentors. Several participants expressed that the interaction with supports of staff, professional, peers and especially mentors have made a huge impact on their development. Yet, the participants stressed that it was these supports combined with the opportunity to take action in their lives through interactive classes, social activities, volunteering, internships, and working that has really made a difference in their vocational development and recovery. This combination of factors has increased many

participants level of readiness to a capacity that enabled them to build on their successes through enhancing their confidence and competence in the moment. The participants explained that these gains then began to build upon one another and led to greater progress in their development and vocational recovery.

Summary of the Quantitative Research

Employment Status of Participants

In the qualitative finding the participants stated that that having an employment internship that was unpaid, being employed or pursuing employment activities has impacted their development and vocational recovery. The participants stated that the activities of choosing, getting and keeping an internship or a job had a positive influence on their development and vocational recovery. Participating in classes, social and community activities, and interacting with and receiving support by mentors, staff and peers helped the participants to see, learn, and achieve their own desired vocational recovery. The quantitative results of the participants employment status support the qualitative finding which document that although there was no statistically significant differences in the number of participants working, the number of hours worked, or the salary of the participants, there was a trend in the desired direction. There was also a positive trend seen in the number of hours worked ($p = 17.5$) and salary ($p = 8.68$).

Of the eight participants (31%) who were employed at the baseline, six participants (23%) maintained employment and two participants who were working at baseline chose not to participate in the study at endpoint so their employment status in

unknown. Eight additional participants obtained employment at endpoint. Of the fourteen participants who were employed the categories of employment were as follows: nine participants (35%) were in independent paid employment, one participant (3%) was using a job coach/supported employment, no participants were volunteering and five participants (19%) were in unpaid employment internships. Twelve participants (46%) were not employed at endpoint but many were involved in educational programs, which will be explained in the next section. While the research indicated that it was difficult for participants to maintain employment, five participants (15%) maintained their employment from the start of the Jump Start program. Overall, the participants who began working at the beginning or sometime during the Jump Start program, 14 participants (43%) maintained some level of employment (Vander Stoep, 1999).

Table 17. A comparison of the Employment Status of Participants at Baseline and Endpoint

Types of Employment	Baseline		Endpoint	
Working-independent employment	6	18%	9	35%
Working –supported employment	0	0%	1	3%
Working-employment Internship-unpaid	0	0	5	19%
Working-volunteer-unpaid	1	3%	0	0%
Not working	26	79%	12	46%

*Please note the percentages do not equal 100% because several participants were involved in more than one category.

Educational Status of Participants at Endpoint

In the qualitative finding the participants stated that having the opportunity to take GED classes in a situated learning environment with positive staff and/or activities has impacted their development and vocational recovery. For example, participants stated that they had made unsuccessful attempts at GED programs before they entered the Jump Start Program or before Jump Start began its GED program, participants stated they were not able to stay in GED programs because the pace was too fast, above their skills level, and/or not individualized enough. The participants stated they valued the personalized one-on one tutoring of the Jump Start program. Four participants (15%) enrolled in Jump Start GED classes and three participants (12%) remained in the Jump Start GED program at endpoint. The fourth participant (3%) dropped because she was committed in a locked inpatient unit and still pursued her GED individually with her mentor.

The participants also stated that they thought the support that they received from both mentors and staff was critical to maintaining their level of success in their chosen educational environment. In terms of being successful in a higher educational setting, the participants stated that both the staff and mentors were an important part of being able to stay in school. In particular, Debbie, Rudy, Amanda and Janet all stated that their mentor was an important source of support in terms of time management, creating manageable study plans, assistance in writing and editing papers, studying for tests and being a supportive listener when problems at school arose. Therefore the participants stated that concrete hands-on learning situated learning experiences and the supported education activities had a positive influence on their development and vocational

recovery. The educational status of participants was as follows: two participants (9%) enrolled in high school at baseline and both participants (9%) stayed in high school at endpoint. The two participants (9%) enrolled in College or University at baseline remained the same as both participants (9%) stayed in College at Endpoint. One participant (3%) enrolled in Community College at baseline and the participant (3%) remained in Community College at Endpoint. One participant (3%) started college during the program but the participant (3%) had to drop out because of financial difficulties. In addition two participants (9%) started Community College during the program and the participants (9%) were still enrolled at endpoint. These quantitative results of the participants' educational status support the qualitative findings because although there was no statistically significant difference in the number of participants, in educational programs there was a trend in the desired direction.

The remaining six participants (23%) were not engaged in educational or employment pursuits but were actively involved in increasing their 'readiness to change' which was a participants ability to prepare themselves to take the necessary changes that would be important to their development and vocational recovery. Many participants expressed their need to take preparatory actions or small positive steps in order to feel that they were progressing on their recovery journey. Many other participants stated the importance of a safe place to transition in order for them to begin to contemplate the necessary steps to make the desired changes in their lives. This concept of 'readiness to change' is a critical yet undocumented step in the development and vocational recovery of participants that has not yet been addressed in the research.

Further research on this critical readiness state will be a crucial part of creating successful strategies to transitions participants to adulthood.

The significance of these results was that the research stated that education programs on all levels were difficult for participants to maintain (Vander Stoep, 1999). These results were particularly significant because twenty-three participants (70%) had received special education services, which revealed the level of learning and cognitive challenges that the participants experienced in educational settings. While the research indicates that it was difficult for participants to remain in educational programs, five participants (19%) maintained education programs throughout the duration of the Jump Start program (Vander Stoep, 1999). An additional ten participants (38%) maintained education programs from various starting points throughout the Jump Start program to the endpoint of the research.

Table 18. Educational Status of Participants at Baseline and Endpoint

Level of School	Baseline N	Percentages	Endpoint N	Percentages
Less than High School	1	3%	1	3%
Some High School	12	36%	12	36%
High School Graduates	9	27%	9	27%
GED	1	3%	1	3%
In GED Program	0	0	3	12%
In Community College	1	3%	3	12%
In College or University	2	6%	2	6%
Bachelor's Degree	2	6%	2	6%

Table 19. Outcomes of the Participants at Endpoint

In College	In Community College	5 Employment Internships	10 are Employed	3 in GED Program	In High School	In Readiness Stage
Amanda	Debbie	David	Bob	Miranda	William	Mark
Rudy	Bob	Janet	Tom	Frank	David	Ralph
	Janet	Jessica	Betty	Cyril		Jim
		Erick	Alison			Sam
		Rudy	Steve			Missy
			Richard			
			Nancy			
			David			
			Jennifer			
			Amanda			

*Please note that the numbers and percentages do not equal 100 percent because several participants are involved in more than one vocational and educational activity. Therefore these participants will also be in more than one column in the chart below. For example, David was working part-time, involved in an employment internship in his desired career field and he was still in high school.
*Please note the participants were underlined after their second appearance on the chart because they advanced or maintained their vocational and educational outcomes in more than one area.

Recovery Attitudes Questionnaire (RAQ-7)

In the qualitative finding the participants stated that they do have a sense of faith and hope in the possibility of recovery and that it was possible to recover. The participants stated that the peer role models in the form of mentoring had an effect on their development and vocational recovery. Interacting with and receiving support by a mentor who has had a psychiatric disability was a positive example, which gave the participants faith and hope that recovery was possible. The quantitative results of the RAQ support the qualitative finding which document that the participants' attitudes

began to shift toward a belief that recovery was possible. The factor to recover requires faith, which approached significance ($p = .059$), indicating an increase in belief of the possibility to recover. The quantitative results were not statistically significant because of a small sample and the length of time of the study was not long enough time to capture the shift quantitatively.

Interpersonal Support Evaluation List (ISEL)

In the qualitative findings the participants stated that they enjoyed having tangible supports and hands on learning opportunities. Participants valued the actual resources that assisted them in their development and vocational recovery such as computers, phones, resumes, and cover letters. Having a place to come to that was welcoming and that had critical supports, like computers, the Internet, resume paper, and photocopy machines was important to them. The quantitative results of the ISEL support the theme of the importance of tangible supports because the results on the tangible subscale indicated movement in the desired direction ($p = .506$).

The participant statements on the importance of peer support, mentor support and social and community activities added to their development and vocational recovery. The belonging subscale, which addressed the perceived ability of people to do things with, also went in the desired direction, which was consistent with the participants' views. Therefore the quantitative results supported the theme of the importance of peer and mentor support because the results on the belonging subscale indicated movement in the desired direction ($p = .396$).

The participants' statements expressed that situated learning situations increased their sense of competence and confidence in themselves. The self-esteem subscale evaluated the perceived availability of a positive evaluation when comparing oneself to others'. The quantitative results support the theme of the importance of situated learning because the results on the belonging subscale also went in the desired direction ($p = .346$).

The participants' statements expressed that their peer role model mentors were an important source of support in their development and vocational recovery. The participants also stated that professional supports, such as psychologists, psychiatrists, and program staff also were significant in their development and vocational recovery. The subscale of appraisal, which assessed the perceived availability of someone to talk to about one's problems was the subscale that experienced the smallest gain over time in mean scores ($p = .793$). Therefore the appraisal subscale did not fully reflect the participants' statements of interaction with mentor support, professional support, family support, peer and program staff support.

Summary of Population Characteristics

Given the amount of ethnic/racial diversity, the number of participants in either treatment institutions or supported housing, the level of dependence on SSI or SSDI, the severity of diagnoses, and the low-level of educational and economic attainment, it can be concluded that this sample was fairly representative of the population of young adults in recent studies and generally reflective of young adults with severe psychiatric disabilities. One of the programs shortcomings was its inability to recruit more Latino

participants despite the fact that they are the fastest growing ethnic population in the United States (National Public Radio, 1997).

Summary of the Implications of this Research

Documentation is scarce on how integrated support systems can collaborate to achieve satisfying experiences of optimal functioning for young adults experiencing severe psychiatric disabilities. Bond, Drake, Becker and Mueser (1999) acknowledged that supported employment, supported education, and skill/support development are regarded as different modalities within psychiatric rehabilitation that contribute to successful vocational outcomes. Returning to work and school are two essential processes that can be critical parts of recovery (IAPSRS, 2000). In the research conducted so far, there is no data collected from the perspective of young adults with psychiatric disabilities that combines career outcomes and their perspective on the impact of support. This perspective is what is most important to capture in a way that reveals what leads to greater development on their vocational recovery.

The quantitative research did not reflect the challenges and successes experienced by some participants in short-term internships, jobs and in returning to college. For example, the statistics showed how one participant transitioned from volunteering to a paid position in a supported employment situation, yet these numbers cannot begin to explain the significance of this change on the participant. The numbers also did not reflect how another participant went from a job waiting tables to a job in his career field and the impact this transition had on his development and vocational recovery. In addition, the numbers were not able to determine that a participant's

experience at an internship that enabled her to successfully transition from commuting at a local state school while living with her family to going to live in the dorms at a University. The statistics also did not allow for a rich understanding of the impact of the experiences that happen exclusively in the middle of the program. For example a participant who started college in the middle of the Jump Start program and left the college due to financial reasons before the endpoint was not even reflected in the data but her experiences with that learning experience have built her knowledge level and competence about achieving her goals that she was just beginning to realize. The charts do not capture the negative effects of being let go from an employment internship because the participants' disabilities did not allow her to be able to meet the demanding requirements of the job. Capturing these transitions from the participants' perspective was what made the qualitative research so valuable.

In the qualitative research, the interview questions were open-ended and able to capture the impact of other factors that could contribute to the development and vocational recovery of the participants. The research questions asked the participants to reflect on their own level of growth and participation in their own developmental process. The strength of the study really lies in the narratives of the participants. The story of how the participants fully participated in their own development truly captures the co-creation of knowledge, action, and change. The research contained quantifiable data but also allowed for personal interpretations of why participants may have experienced success or setbacks in their lives. Through this combination of quantitative and qualitative research, there was a meaningful interaction between participant's input and statistical data that can be used to influence and educate legislature and other

funding sources on the importance of family support, supported education and supported employment to the development and vocational recovery of young adults with severe psychiatric disabilities.

It is true that the statistical power was limited due to the sample size, the level of sensitivity of the quantitative instrument, and the information it captured. Yet nothing could replace the qualitative analysis of the participants' personal meaning making of their experiences. Allowing the important themes to emerge from the participants' own words has been an informative and invaluable process. This type of rich and revealing data was not accessible by quantitative data. Therefore due to breadth and depth of this intensive research, there was a greater understanding of the participants' meaning making process and what could enable them to be more satisfied and successful in their development and vocational recovery.

CHAPTER 6

RECOMMENDATIONS AND IMPLICATIONS FOR SYSTEMS, PROGRAMS, PEOPLE AND RESEARCH

Systems

The importance of supports and the complicated nature of delivering supports to young adults with severe psychiatric disabilities was the most significant finding of this research. Abraham Lincoln stated, " the worst thing that one can do for someone is something that they can and should do for themselves." In a time of restricted and continuingly diminishing resources for individuals with psychiatric disabilities, it is critical to determine what level and form of support is most beneficial for the young adults.

Many of the participants face such significant challenges that it is difficult to know how, when and where to intervene in a way that promotes not thwarts their inner competencies. For some of the participants, life is a continual series of crises. Many participants went through multiple crises throughout the program. These included, but were not limited to, financial problems, difficult housing situations, homelessness, transitioning out of a psychiatric hospital, unplanned pregnancy, pregnancy scares, being committed to a psychiatric hospital, engaging or relapsing into drug or alcohol abuse, job loss, death of a parent, a parental relapse into alcoholism, psychotic episodes in which they hurt themselves or at times others, symptom flare-ups, and medication changes.

In particular, medication changes had a significant impact on the participants' participation in the program. As a result of the medication's severity, their lives were

disrupted for days, weeks or months at a time- depending on the dosage and whether their system reacted positively or negatively to the medication. Medication in terms of severe psychiatric disability is far from an exact science. Oftentimes a student will have to undergo many different forms of medications and many changes in dosages to find the combination that works best for him or her with the least side effects. In a time when for young adults body image is so critical, many young adults with severe psychiatric disabilities struggle with eating disorders partly because many medications cause significant weight gain. With so many challenges facing these young adults with severe psychiatric disabilities, an individual may wonder is it even worth it to attempt to support them? How could these participants ever progress toward recovery, let alone actually recover.

Some of the participants' parents in Jump Start were told that their children would never leave a psychiatric hospital and would not be able to function without continuous care because of the level of psychosis their child was experiencing. Other participants could not even control their bodily functions as early adolescents as a result of their psychosis and high level of medications. Still others struggle with parents who deny sexual abuse by a step-parent ever took place and want the student to call that person "daddy". Other participants face the problems of restraining orders or court orders out against them because of incidents with girlfriends or children. It is difficult enough to be a young adult today with all the intense pressures surrounding today's youth, without the added pressure of a psychiatric disability that compromises a young adult's ability to assess situations, determine consequences and take appropriate action.

How does a system even begin to think about supporting these young adults with so many obstacles in the way of their recovery?

The research documented that effective supports enable the participants to form connections to one another, the staff and their surroundings. One of the greatest challenges of a young adult experiencing psychiatric disabilities was the inability to create genuine connections with themselves, other people, places and communities. Many participants stated that they lacked the inner capacity or coping competence to create meaningful and lasting ties to people and situations. Several participants maintained that the reason they came to the program was to "connect" in some form or another. Life is about relating and connecting to others, establishing a rapport, recognizing similarities and acknowledging differences; yet many of the participants shared that this was their most challenging struggle. Several participants shared that it was this sense of disconnection and incapacity to reach out that caused intense pain and distress in their lives. Some participants wanted to connect with other peers like themselves; some wanted a stronger connection to themselves in the form of self-awareness or a mind-body connection; while other participants wanted a genuine connection with anyone who would listen, whether it was mentors, staff, another student, or a person at their volunteer site or job. Still other participants wanted to reconnect to a lost role or establish a new role. For example, one student picked up his backpack and wanted to regain the student role, another student wanted to change his role from that of a shy student to that of a personable student, a third student wanted the role of a worker instead of being someone who sat on his parent's couch. Many participants were uncertain of what role they wanted to obtain. Therefore, several

participants expressed that they needed the assistance of the classes, the staff, the other participants and/or their mentors to determine what role they wanted to obtain and then also required some assistance in creating a plan to achieve this goal.

The participants were clear in saying that it was necessary for supports to be delivered in non-judgemental, personalized, flexible and consistent ways. The participants wanted many varied levels of involvement to meet their specific needs. There also needed to be a series of different points of entry or re-entry. Many participants were not at a point of readiness to accept, or even begin, to confront the issues of having a diagnosis of a severe psychiatric disability. Therefore, at many points of the program, they did not have the capacity to take advantage of many of the services, so the ability to reengage at different points was critical.

The research found that a flexible structure was critical and allowed for the system to acknowledge the student as a whole person focusing on and embracing the strengths as well as acknowledging and addressing their limitations. The findings also suggested that the participants thrived in a system that encouraged them to interact in hands-on and concrete ways that valued them as individuals participating in a meaningful community. Also, the findings state that it is critical to provide peer support in the form of mentor role models who can assist the participants by both modeling and supporting them in their recovery. Several participants stated that this type of synergy begins at the programmatic level, which will be discussed in the next section in detail.

Programs

This section of the chapter represents practical actions that emerged from the research for helping new programs to assist participants in their development and vocational recovery. Young adults with severe psychiatric disabilities have the highest unemployment rates, the lowest participation in postsecondary training and education programs, and the highest likelihood of remaining dependent on public assistance programs following high school (Davis & Vander Stoep, 1997). There is such a low rate of participation in post-secondary training and education programs for young adults with severe psychiatric disabilities and it is a known fact that there is a direct correlation between the level of education a young adult receive and the level of income he or she is able to obtain. Therefore participants stated that this was a critical issue in program development.

The research found that the way services are delivered to young adults with severe psychiatric disabilities must be different than the way it is delivered for adults with severe psychiatric disabilities. Several participants stated that they did not want to travel across town to sit in a sterile office of a counselor or doctor whom they don't know and whom they felt that they had nothing in common with, to talk to them about a diagnosis that they don't want. Many participants stated that one of the most important things to the recruitment and continued participation was the location and environment of the program. The participants stated that their environment should match or be close to the situation that the participants were trying to be part of i.e., a work or school setting. Several participants pointed out that most mental health services have totally

artificial environments that were not developmentally or vocationally appropriate to their lives or their goals.

Many participants stated that social stigma and discrimination due to living with a severe psychiatric disability has meant an end to goals, dreams and ambitions and they wanted a program that provides not only skills and education but real life examples through the form of peer mentors who have gone on to have successful careers and satisfying lives. Several participants stated that having a more educationally-orientated rather than treatment orientated system-less focus on clinical-more emphasis on skills development and teaching would reverse this dead-end mentality for many participants. The message that participants want the system to convey to young adults with severe psychiatric disabilities is that development and vocational recovery is possible.

Many participants stated that an educational setting, ideally a university setting was a desirable location for a program. The reasons the participants stated are as follows: participants liked to be associated with a higher learning institution because being associated with a college takes away any stigma or discrimination associated with a mental health setting. Many participants enjoyed being part of a learning community. The idea of taking classes and not going to groups was very appealing, and the fact that they were learning new skills and not simply discussing their issues was also attractive.

Several participants liked being on a college campus and taking on the role of a student instead of a patient. A student has plans for a future, important goals and worthwhile dreams to pursue. In contrast, a patient has a treatment plan that must be followed. It is apparent which label a young adult would seek to wear. Participants stated that they would rather be a student and carry a backpack and a syllabus then be a

patient with a list of medications and rooms of groups that he or she is required to attend.

Many participants expressed that there must be clear and positive expectations in the classes but enough flexibility to allow them to take advantage of the opportunities. Participants appreciated that Jump Start had four ways to participate. The participants had the opportunity to participate in the program on various levels as well as receive supported employment services from both staff and mentors. The four different ways, explained in more depth earlier in the paper, for the participants to participate were 1) to have a mentor and meet with him or her weekly; 2) to participate in career development, wellness and/or computer training classes; 3) to have individual meetings with staff on career or personal development issues; and/or 4) to attend social events.

Due to the level of stress and challenge facing participants, the research anticipated a significant level of experimental mortality or attrition. This population was extremely at risk because they experience severe psychiatric symptoms including debilitating depression, anxiety, suicidal thoughts and hallucinations. Therefore the participants' participation in the program was severely hampered. In order to help maintain participation levels, the research was extremely flexible in its criteria for participation. The research included a definition of participation as any level of contact with the program. The research maintained that the ability to meet the participant's level of readiness and to acknowledge what the participants believed was their capacity to participate at this time was critical to the participants' individual progress.

The Advantages and Challenges of Mentors as Peer Role Models

As touched on above, the research has also demonstrated that peer role models and peer support were critical to the development and vocational recovery of the participants. Many participants were matched with mentors who had faced similar challenges with their own psychiatric disabilities. Several mentors became friends, confidants, and peer models who supported the healthy development of skills, social support and career advancement of the participants. Numerous participants stated that the existence and strength of the mentor connection was extremely important to them. Most participants stated that the mentor match was the most important factor in whether or not the participant stayed with the program and it also impacted their level of participation in the program.

However due to the critical nature of the mentoring relationship, it is important to acknowledge that a few participants were angry, hurt or disappointed when a mentoring relationship was not able to be formed or the connection was not able to be sustained. The participant often felt guilty, disconnected or angry as a result. The reasons for these "disconnects" varied. Geographic location was a big factor in the relationship because of transportation. Many participants expressed a lot of difficulty and stress navigating public transportation especially if it was later on in the day or at night.

Some mentors were not able to fulfill their mentoring commitments because of circumstances beyond their control. These were day-to-day life challenges that could not have been anticipated. Two mentors had to end their mentoring commitment because their psychiatric disabilities became unmanageable for them. One mentor had a

death in the family, another mentor changed jobs, and a third moved to another state for a better job. Some participants never quite rebounded after a poor mentor match and would not allow themselves to fully participate in the program because they did not want to open themselves up to hurt and disappointments any further. A few participants became completely frustrated and disillusioned with the idea of mentoring and two participants' connection to the program became completely strained and then ended. Numerous participants stated that the mentors were a critical link to the program in a special and valuable way and when that connection was strained or severed then sometimes so was the participants' participation in the program. That was one of the most challenging parts of the program, to attempt to reconcile the expectations of the participants when the mentors were not able to meet their commitments to the participants.

In a report submitted by Consumer Quality Initiatives, Inc., to the Massachusetts Department of Mental Health, mentoring was named as a critical support to assist young adults in navigating the transition to adulthood (Delman & Jones, 2002). Numerous participants stated that these mentors played an extremely valuable role in their lives. Several mentors provided a living example that recovery was possible and that a diagnosis did not mean the end of their career and life aspirations.

Several participants pointed out that learning new skills and being part of the community were crucial to their development and vocational recovery. Participants wanted to have the same "normal" experiences of growing up as their peers- completing school, finding a job, making friends- but often lacked the skills, supports and opportunities to do so. Some participants stated that the mentors were a tremendously

valuable part of helping to "test the waters" by supporting them in making their own choices and decisions, while providing them guidance throughout the process. Several participants who felt or had been told that they may not be very good at anything or that their diagnosis would limit or destroy their dreams were often unsure about what to do with their lives. Many participants explained that their mentors spent energy, time and effort showing them that they had opportunities and choices. Some participants pointed out that a successful program should not only try to address the "normative" issues facing young people, but also the unique needs of young adults at various stages in the process of coming to terms with having a severe psychiatric disability.

Numerous participants shared that the mentors were a constant source of support and encouragement who truly understood the daily realities, frustrations and challenges of living with a psychiatric disability and were able to share some successful strategies of how to deal with it. The participants pointed out that they needed concrete and constructive experiences to be able to effectively transition into adult roles and responsibilities. Participants noted that the mentors were able to help them with the practical challenges in daily life. By showing the participants how they deal with time management issues, create and follow a schedule and how to balance a budget, the participants stated they were able to see first hand that self-sufficiency and independent living was not only possible but it was the day-to-day reality of their mentors. Decision making skills including positive reframing of experience, and breaking down consequences of actions, are also important skills that the participants stated were crucial to their development that the mentors worked on with them. For example, participants explained that mentors assisted them in thinking through the impact of

potential decisions. The mentors helped participants determine "if I do this, what will be the impact in my life" in a less judgmental way than a parent or service provider might.

Several participants also shared that positive peer socializing was essential to their well being. Program activities such as going bowling, playing pool, going to sporting events and playing softball together made the program more attractive to the participants and also helped them to practice and enhance their social skills in real life settings. Participants affirmed that it was so much more beneficial to have participants work on their social skills in a situation where they actually might make and keep friends.

The Link between Situated Learning and Career Development

Participants stressed that the practical application of situated learning also was essential to their development and vocational recovery. Situated learning maintains that passively receiving knowledge, "transmission", is not a valid form of learning because the person is not engaged in or feeling part of a meaningful context, activity or group (Lave & Wagner, 1991). The participants expressed that they did not idly sit and absorb the material in Jump Start; they were challenged to participate as well as create the situations or at least the groundwork for the opportunities that the participants sought. The participants explained that the classes connected career and life skills together and drew from relevant real life examples, which was critical for them.

Participants felt that instructors in career planning classes supported them in trying to achieve the right match for their unique talents and strengths. Participants

stated that career planning classes covered topics such as building a resume, creating a cover letter, how to sell yourself to the right employer, job getting and keeping strategies, how to understand a company's work culture, how to make yourself a valued employee, how to handle challenging co-workers and bosses, and how to create a long-term career plan.

Participants declared that education, volunteering, internships and work were all important parts of recovery. Developing skills has the potential to help young adults maintain employment and be effective participants and/or employees. In career classes, the participants expressed that they should be educated about how to make informed decisions about their careers, given what is important to them. Participants declared that they wanted to be supported to research potential jobs, companies, colleges and careers using the Internet, libraries, visiting companies and through informational interviewing. As participants progressed, they wanted to be encouraged and assisted in seeking further schooling, volunteering, internships and/or paid work. Participants stated they wanted career classes to feature structured lessons, presentations and guest speakers in a discussion format that encourages participants to share and learn from one another's experience as well.

People

The significant results of this study have illuminated that participants need mentors-peer role models- who had faced similar challenges in order to successfully transition into adulthood. Participants told us that they needed to be supported not

merely managing symptoms but in striving to live well, develop skills, and achieve re-integration into the community through education and personal growth.

The results also have implications for the principle of person-centered planning. Many participants needed to feel that their interests, skills and abilities were being validated and that their opinions and preferences were being taken into consideration. Several participants declared that they wanted to take the lead role in their own development and vocational recovery. Numerous participants stated they needed educational and employment opportunities to develop their confidence and competence in relevant situations that are supportive and challenging.

Research

One of the key implications of this research was the apparent need to study the impact of how vocational rehabilitation and supported education programs influence the vocational recovery of participants. In the previous research there is no perspective that acknowledges the combination of the career outcomes and the impact of support research perspective of individuals with psychiatric disabilities. Therefore, these interplay of these two research approaches are critical for participants in their vocational recovery. For that reason, future research should assess the long-term effects of supports and vocational recovery together in terms of educational attainment, financial security, and career prestige.

The development and educational recovery of participants will continue to be of pressing concern with the limitations and the changes taking place in the health care system. The results of this study dramatically underscore the need for further research

to address the significant gaps in the literature. Qualitative and quantitative research are clearly necessary to understand more specifically the level and types of supports that are necessary to assist young adults with severe psychiatric disabilities to successfully transition to adulthood.

More longitudinal studies are required to fully understand the interaction of recovery, supported education, supported employment and family support of the development and vocational recovery of this population. The lack of significance found in traditional instruments such as the Recovery Attitudes Questionnaire (RAQ) and the Interpersonal Support Evaluation List (ISEL) draws attention to the fact that other measures should be developed as possible predictors.

Comparison studies of programs that offer services to assist participants with their development and vocational recovery will also be important. Investigating the influence of support on educational and employment outcomes over extended periods of time will be critical in determining which supports are the most essential. It is recommended that larger samples be used to better identity the components, which are likely to have an impact on a range of outcomes.

Based on the findings, the researcher recommends five directions for further study which include:

1. A longitudinal study with a larger sample an as examination of participants' experiences with education and supports;
2. A study designed to identify the variables, which foster young adults readiness to change their behaviors.

3. A study that looks at what specific factors affects participants' ability to change their behaviors;
4. A study that examines what influences participants' ability to create their own support system.

Summary

After a review of the theoretical foundations and the research in the development and practice of psychiatric rehabilitation, it is clear that supported education, supported employment, and forms of support that facilitate positive relationships for participants are important elements in the recovery process. The timing and types of support are also critical. These supports need to match participants readiness and developmental stage. Even more central to the discussion of how to achieve educational and vocational recovery is the ability of individuals to develop the skills necessary to create their own support systems. This challenge for individuals with psychiatric disabilities has yet to be sufficiently investigated, particularly in relation to its ability to have an effect on employment outcomes.

The participants' and mentors' words not only support what is already documented in the research, but also provide a unique contribution and add an especially rich insight into the level and types of support that enable individuals to achieve satisfaction and success in their chosen career and educational pursuits. Young adults experiencing severe psychiatric disabilities require and benefit from the same developmental and vocational opportunities as other young adults. Young adults experiencing severe psychiatric disabilities are untapped resources who require extra

support to identify and develop their gifts and talents so that they may become valuable and contributing citizens.

Young adults with severe psychiatric disabilities face numerous and significant life challenges including: financial problems, difficult housing situations, homelessness, substance abuse, stigma and symptom relapse. The participants in this study continually faced obstacles and setbacks but most remained committed to the complex struggle toward their recovery. Therefore, it is hoped that the findings of this study will inform the creation of effective, developmentally appropriate, vocationally and educationally stimulating experiences for young adults experiencing severe psychiatric disabilities that along with their families, mentors, service providers, and communities and researchers will support them in their recovery process.

This study is significant because it captures rich personal narratives and it also comprehensive enough to provide valuable information about the broader experiences of young adults experiencing severe psychiatric disabilities. Recurring themes emerging from the data made it clear that there were consistencies among the experiences of young adults with severe psychiatric disabilities. The participants thoughts were organized under themes and then elaborated on to further clarify the participants' beliefs and experiences. This study is groundbreaking because it combines diagnostic information, quantifiable employment and vocational data, and in-depth qualitative interviews. These mixed sources of data add value to the research endeavors in this field and at the same time, honor the personal lived experience and of the individuals. The participants' own words provide a unique and rare glimpse into their meaning making process of these young adults. This research elucidates the perceptions and experiences

of these young adults with psychiatric disabilities providing a rich range of descriptions into challenges they faced and the skills they obtained. On a personal level this project has influenced the way many of the young adults and the mentors in this project view themselves and their role in the world. This project also makes an exceptional contribution to the field of psychiatric rehabilitation by greatly increasing our understanding of the development and vocational recovery process of young adults experiencing psychiatric disabilities. The implications of this research have the potential to improve the effectiveness and sensitivity of services and supports available to this vulnerable population.

APPENDIX A

INSTRUMENTS

Mentee Final Interview Questions

Introduction:

"You've been a participant in Jump Start Program for the past 10 months. While a student in Jump Start, you've had the opportunity to learn new things and develop new relationships. You've probably also had experiences outside Jump Start that have made an impact on you. I am going to ask you a little more specifically about the things you've learned, the ways you've changed and the valuable relationships you've made during the last year both within Jump Start and in other areas of your life. I am not looking for any particular answers. I am interested in hearing your personal perspective on what things have been like for you, so please be as honest as possible."

1. To begin, think about the kinds of relationships you've had over the last year.
   A. As part of Jump Start, you may have connected with a lot of different people.

   Tell us about any relationships you may have developed with staff?
   What about any (the) relationship(s) you developed with…
   - Other students?
   - Your mentor?
   - Career or school contacts
   - Is there anyone else that you developed a valuable or supportive relationship with as a result of being involved in Jump Start.

   B. What about people outside of Jump Start? Tell us about any other valuable or supportive relationships you've had during the last 10 months?

2. Now I'd like you to think about the kinds of things you may have learned from classes associated with Jump Start (Prompt-Career classes, computer classes, Recovery center classes-:Remember we did things about informational interviews, resumes, cover letters, mock interviews, etc.)

   A. With respect to the classes, what did you find most helpful? Can you tell me more about that?
   B. What did you find most interesting? Can you tell me more about that?
   C. What did you enjoy the most? Can you tell me more about that?

3. Now I'd like you to think about experiences you've had outside of Jump Start? Is there anything that happened to you or that you did during the year that has made a real

impact on you? Can you tell me more about that? Anything else? (Prompt for thinking learned and/or people met, etc.)

4.What have you've learned about yourself during the last year?

I. Mentor Feedback and Evaluation Survey

We sincerely appreciate everything you have done as a mentor in Jump Start! The program has been such a great success largely as a result of the role you've played in the lives of our students. We'd like to take a few moments to get a little bit more feedback from you on your experiences as a mentor, your relationship with your mentee(s), and ways in which we could improve the training/supervision mentors receive for future projects. Please answer the questions below as thoughtfully and honestly as possible.

1.How have you been impacted by your experiences as a Jump Start mentor?

2. How do you think you've been most helpful to/supportive of your mentee?

3. What do you think has been the most valuable aspect of being a mentor?

4. Are there any aspects of mentoring that you have found particularly problematic or challenging? Please explain.

5. What have you learned about yourself as a result of being a Jump Start mentor?

6. Has your relationship with your mentee changed over the course of the project? If so, how?

7.Are you going to continue your relationship with your mentee? Please explain why or why not.

8.What aspects of the training and/or supervision provided was most helpful to you?

9. Are there topics/issues that were not covered in the mentor training/supervision that you wish had been addressed? Please explain.

10.What advice would you give to someone planning to be a mentor for a future program like Jump Start?

11. Please use the space below to say anything else you'd like to about your experiences as a Jump Start mentor.

Interpersonal Support Evaluation List (ISEL)- General Population

This scale is made up of a list of statements each of which may or may not be true about you. For each statement check "definitely true" if you are sure it is true and "probably true" if you think it is true but are not absolutely certain. Similarly, you should check "definitely false" if you are sure the statement is false and "probably false" if you think it is false but are not absolutely certain.

1. There are several people that I trust to help solve my problems.
   ___definitely true(3) ____definitely false (0)
   ___probably true (2) ____probably false (1)

2. If I needed help fixing an appliance or repairing my car, there is someone who would help me.
   ____definitely true (3) ___definitely false (0)
   ____probably true (2) ___probably false (1)

3. Most of my friends are more interesting than I am.
   ____definitely true (3) ___definitely false(0)
   ____probably true (2) ___probably false (1)

4. There is someone who takes pride in my accomplishments.
   ___ definitely true (3) ___definitely false (0)
   ____probably true (2) ____probably false (2)

5. When I feel lonely, there are several people I can talk to.
   ____ definitely true (3) ____definitely false (0)
   _____probably true (2) _____probably false (1)

6. There is no one that I feel comfortable to talking about intimate personal problems.
   ____ definitely true (3)____definitely false (0)
   ____probably true (2) ____probably false (1)

7. I often meet or talk with family or friends.
   ___ definitely true (3) ___definitely false (0)
   ____probably true (2) ___probably false (1)

8. Most people I know think highly of me.
   ____definitely true (3) ____ definitely false (0)
   ____probably true (2) ___ probably false (1)

9. If I need a ride to the airport very early in the morning, I would have a hard time finding someone to take me.
___ definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

10. I feel like I'm not always included by my circle of friends.
___definitely true (3) ____ definitely false (0)
____probably true (2) ____probably false (1)

11. There really is no one who can give me an objective view of how I'm handling my problems.

____definitely true (3) ___ definitely false (0)
____probably true (2) ___ probably false (1)

12. There are several different people I enjoy spending time with.
____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

13. I think that my friends feel that I'm not very good at helping them solve their problems.

____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

14. If I were sick and needed someone (friend, family member, acquaintance) to take me to the doctor, I would have trouble finding someone.
____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

15. If I wanted to go on a trip for a day (e.g. to the mountains, beach, or country), I would have a hard time finding someone to go with me.
____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

16. If I needed a place to stay for a week because of an emergency (for example, water or electricity out in my apartment or house), I could easily find someone who would put up with me.
____definitely true (3) _____definitely false (0)
____probably true (2) _____probably false (1)

17. I feel that there is no one I can share my most private worries and fears with.
____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

18. If I were sick, I could easily find someone to help me with my daily chores.
____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

19. There is someone I can turn to for advice about handling problems with my family.
____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

20. I am as good at doing things as most other people are.
____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

21. If I decide one afternoon that I would like to go to a movie that evening, I could easily find someone to go with me.
____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

22. When I need suggestions on how to deal with a personal problem, I know someone I can turn to.
____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

23. If I needed an emergency loan of $100, there is someone (friend, relative, or acquaintance) I could get it from.
____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

24. In general, people do not have much confidence in me.
____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

25. Most people I know do not enjoy the same things I can do.
____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

26. There is someone I could turn to for advice about making career plans or changing my job.
____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

27. I don't often get invited to do things with others.
____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

28. Most of my friends are more successful at making changes in their lives than I am.

____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

29. If I had to go out of town for a few weeks, it would be difficult to find someone who would look after my house or apartment (the plants, pets, garden, ect.)

____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

30. There really is no one I can trust to give me good financial advice.

____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

31. If I wanted to have lunch with someone, I could easily find someone to join me.

____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

32. I am more satisfied with my life than most people are with theirs.

____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

33. If I was stranded 10 miles from home, there is someone I could call who would come and get me.

____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

34. No one I know would throw a birthday party for me

____definitely true (3) ____definitely false (0)
____probably true (2) ____probably false (1)

RECOVERY ATTITUDE QUESTIONAIRE (RAQ-7)

Recovery is a process and experience that we all share. People face the challenge of recovery when they experience the crisis of life, such as the death of a loved one, divorce, physical disabilities, and serious mental illness. Successful recovery does not change the fact that the experience has occurred, that the effects are still present, and that one's life has changed forever. Rather, successful recovery means that the person has changed, and that the meaning of these events to the person has also changed. They are no longer of primary focus on the person's life. (Anthony, 1993).

We are interested in measuring your belief about the concept of recovery from mental illness. Please read each of the following statements and using the scale below mark the rating that most closely matches your opinion.

SA	A	N	D	SD
Strongly agree	Agree	Neutral	Disagree	Strongly Disagree

1. People in recovery sometimes have set backs.	SA	A	N	D	SD
2. To recovery requires faith.	SA	A	N	D	SD
3. Stigma associated with mental illness can slow down the recovery process.	SA	A	N	D	SD
4. Recovery can occur even if symptoms of mental illness are present.	SA	A	N	D	SD
5. Recovering from mental illness is possible no matter what you think may cause it.	SA	A	N	D	SD
6. All people with serious mental illnesses can strive for recovery.	SA	A	N	D	SD
7. People differ in the way they recover from a mental illness.	SA	A	N	D	SD

Thank you for taking the time to fill out the questionnaire.
Please direct any comments or questions to
John Steffen or Hillary Wisnick at (513) 556-3324
Hamilton County Recovery Initiative Research Team (HCRI-RT)

Supported by the Office of Program Evaluation and Research, Ohio Department of Mental Health.
Sponsored by the Multidisciplinary Program Consortium, A Center for Training & Research in Serious Mental Illness.

APPENDIX B

INFORMED CONSENT

Informed Assent/Consent for Jump Start Students

Title of Study: A Process and Outcome Evaluation of a School to Work Transition Program for young adults with psychiatric disabilities.

Co-Principal Investigators: E. Sally Rogers, Sc.D.
Marianne Farkas, Sc.D.
Center for Psychiatric Rehabilitation
Boston University
940 Commonwealth Avenue
Boston, Ma. 02215

Purpose of the Project:

The purpose of this research project is to conduct a program evaluation of a model of service delivery that assists in the school to work transition called Jump Start. The university-based Jump Start Program will provide vocational and wellness services through courses that build awareness, develop skills and provide supports to young adults, age 16-26, with psychiatric disabilities. It is anticipated that participation as a student in the Jump Start program will result in improved vocational outcomes and support levels as well as positive changes in attitudes about recovery.

Description of the Study:

As a student in the Jump Start program, you will be asked to participate in courses and individual meetings that are offered throughout the week for two semesters. You will be asked to choose from the array of courses offered and meet with a Recovery Mentor on a regular basis to help you choose and succeed in the classes as well as choose, get and keep employment. The courses will take place in classrooms at the Center for Psychiatric Rehabilitation at Boston University. The classes will run on a semester basis, February to May and May to October. As part of the study, you will be asked to meet with a researcher when you enroll and when you leave the program for an interview that will be audio-taped. During the interview you will be asked to fill out self-report questionnaires that relate to your attitudes about recovery, your levels of support in your life, and changes in your vocational or educational status, your housing status and your health status. In addition, you will be asked questions about the role that different supports may have in your recovery. The interviews are expected to last 1.5 hours.

Study Procedures:

The first part of the program will involve participation in an orientation session where you will have the opportunity to hear about the courses in detail, make informed decisions regarding which courses best meet your needs and interests, meet the faculty of the Jump Start Program and choose a Recovery Mentor with whom you will have individual meetings. Additionally, you will be asked to meet with a research assistant to fill out paper and pencil instruments that measure attitudes of recovery, support

levels, employment status, educational status, and housing status. The data collection process will be audio-taped and will take approximately 1.5 hours. This interview will occur two times, when you enroll in the program and when you leave the program.

In addition, services staff in the Jump Start Program will complete a computerized clinical activity note after completion of every individual meeting and class that you participate in. These clinical forms include your name and detail what rehabilitation process you engaged in with the staff and for how long. These activity notes will help us measure what rehabilitation processes that staff provide help promote recovery.

Confidentiality:

Any information you provide staff through interviews, individual meetings, classes and testing will be considered confidential (within the limits of the law) and will be stored on our computerized management information system. Several levels of security have been installed to ensure the privacy and safety of your personal information. Your name will be on a password protected master list and assigned a numerical code. Only the Study Director and Research staff will have access to this list. All research data and tapes will be coded with an ID number so that no names appear on them. The research data and tapes will be stored in a locked file cabinet in a locked office at the Center for Psychiatric Rehabilitation. Following the completion of the study, the audiotapes will be destroyed. All data will be combined so we may look at and report on project participants as a group. No information regarding your individual participation will be released to any outside agency or person without your expressed and written consent.

Risks/Benefits:

There are no known personal risks for participating in this study. Some of the questions might be considered sensitive, since they will ask you questions about your disability, your health status, and job status. You may at any time refuse to answer questions you find upsetting without jeopardizing your status as a student. If you choose to withdraw from the study, you may request that all data collected be destroyed without jeopardizing your status as a student.

Benefits that may occur as a result of your participation include individual counseling sessions with a faculty member of The Jump Start Program to support your progress in the recovery courses and in choosing, getting and keeping employment. You may also experience increased positive attitudes about recovery along with positive changes in your role status and levels of support in your life.

Informed Consent/Assent

Statement of Consent/Assent

I have read the above statement. I have had the opportunity to ask questions and they have been answered to my satisfaction. If any questions arise during my participation about the study I may contact:

Co-Principal Investigators:

Dr's. Sally Rogers and Marianne Farkas
Center for Psychiatric Rehabilitation
Boston University
940 Commonwealth Avenue West
Boston, Ma. 02215
617-353-3549

If any questions arise during the study about my rights as a human subject I may contact:

Coordinator of Boston University Institutional Review Board:
II. David Berndt

Charles River Institutional Review Board
Office of Sponsored Programs
Boston University
25 Buick Street
Boston, Ma. 02215
617-353-4365

I understand that my participation in this study is completely voluntary. I understand that I may refuse to participate or withdraw from the study at any time without leaving The Jump Start Program. If I choose to withdraw from the study, I understand that I may request that all data collected will be destroyed. I understand that I will receive a copy of this consent/assent form for my records. I have read the information above and agree to participate:

_____ _____
Signature of Participant Date

_____ _____
Person Obtaining Consent Date

_____ _____
Guardian Consent (If applicable) Date

APPENDIX C

DESCRIPTION OF THE JUMP START PROGRAM

Description of the Jump Start Program

The young adults with severe psychiatric disabilities participated in the Jump Start program on various levels as well as received supported employment services from both staff and mentors. The four different ways the participants participated were 1) met with a mentor; 2) attended career development, wellness and/or computer training classes; 3) attended individual meetings with staff on career or personal development issues; and/or 4) attended social events. At first, the program sought to require both regular weekly meetings with a mentor and participation in at least one career class per week. Yet, with the extremely diverse needs and preferences of the young adults entering the program and the program's emphasis on the value of choice, we decided participants could chose which services best met their needs. Participation was defined as being in contact with a mentor either by phone or through individual meetings, attendance in one or all of the classes, or just interacting with a particular staff person with whom they have formed a connection. The program maintained that it was extremely important that the program had the capacity to meet the participants where they are and to acknowledge and respond accordingly to the participants' capacity to participate. In honoring the participants' level of participation, the participants were able to customize as well as optimize the services they chose.

Explanation of the Mentor Component

In the first component of the program, the young adults were matched with mentors who had faced similar challenges as the young adults face with their own psychiatric disabilities. These mentors were friends, confidants, and peer models who supported the healthy development of skills, social support and career advancement. In

a report submitted by Consumer Quality Initiatives, Inc., to the Massachusetts Department of Mental Health, mentoring was named as a critical support to assist young adults in navigating the transition to adulthood (Delman & Jones, 2002).

The mentors worked in a range of successful and satisfying careers. Jump Start recruited 17 mentors for the program and 14 were actively engaged with participants throughout the program both through individual meetings as well as tutoring in Graduate Equivalency Diploma (G.E.D.) classes. The mentors were 53% female and 47% male. The career fields of the mentors ranged from education and human services to technology to law. Specific careers of the mentors included a post doctoral participant working at a hospital, several teachers, a camera operator, a career specialist, an artist, a computer consultant, an executive director at a human services agency who was also a lawyer, a psychologist, and a data entry specialist at a consumer credit counseling company.

Mentor Trainings

The mentors attended an initial two-day training and attended monthly trainings throughout the program. The collaborative expertise of center staff created training topics and curriculum that addressed the skill needs of the mentors. Training topics included:

•Who Mentored You? An Introduction to Partnership Skills for the Mentor Relationship-Orientation To the Program and to the Role of Mentor. -The instructors encouraged people to think about what mentoring was from their own experience.

•Making the Most of Your Match –The instructors taught partnership skills for the mentor relationship. The instructors presented practical information and skills to help foster and maintain trusting and supportive relationship. The instructors taught the mentors the skills of listening, paraphrasing and responding skills.

•The Role of the Mentor -The instructors suggested possible activities for the mentors to do with the mentees. The instructors discussed the importance of connecting with your participant and strategies for engagement. The instructors encouraged the mentors to talk about their experience in the relationship so far.

•Setting Appropriate Boundaries –The instructors reviewed strategies for creating comfortable and safe boundaries within the mentoring relationship. The instructors went over self-disclosure and how to share your personal experiences related to one's psychiatric disability.

•Promoting the Career Development of your Mentee –The instructors taught the process of helping participants Choose, Get and Keep employment and education goals.

•The Needs of Young Adults- Dr. Mary Ann Davis presented the developmental and social stages of young adulthood as impacted by psychiatric disability.

•How is it Going? Brainstorming Solutions for Difficult Situations –The instructors encouraged mentors to bring scenarios to the training and strategized supports and solutions for the challenges arose in the relationships.

•Beginning to End your Mentoring Relationship-The instructors taught the mentors how to successfully terminate the mentoring relationship if they chose to. The instructors discussed the possibilities for transitioning the relationship into a less formal arrangement.

•Next Steps in the Mentoring Relationship-The instructors responded to the mentors questions and concerns about the transitioning process and explained the various levels of staff support that would still be available to the mentors even though the formal group training was ending.

The mentor training also included attendance at the Boston Film Festival to view the film, *"People Say I'm Crazy"* which portrayed a real-life story of an artist's struggle with schizophrenia. After the film, the star John Cadigan and his sister, Katie, the film's director, facilitated a thought-provoking discussion about the making of the film. This was the first film ever made by a person with schizophrenia.

Significance of the Mentor Training

The trainings provided a forum for the mentors to develop the skills necessary to mentor successfully and to share with one another ways of connecting to and supporting the participants in their development and vocational recovery. The trainings offered

opportunities for the mentors to connect and exchange stories of what was working and not working in their relationships.

For additional support, we matched the mentors with a staff person for personalized supervision. This supervision occurred via email correspondence, phone conversations or in person depending on the needs and preferences of the mentor. In addition to having the training and supervision, the program paid the mentors fifteen dollars an hour for supporting their young adults. The program also paid mentors for the monthly training sessions and for time spent in supervision meetings. The mentors had one, two or three participants depending on their schedules and other commitments. The guidelines suggested that the mentors spend a minimum of one hour a week with each participant and up to a maximum of three hours per week.

The activities of mentors and participants provided opportunities to connect to one another as individuals with diverse interests, skills and abilities. Some of these activities included

- playing basketball
- working out at the gym
- talking over coffee
- meeting at McDonalds
- playing pool
- attending ball games
- supportive phone calls
- going to the movies
- eating at one another's house for dinner
- working on resume and cover letters together
- going to career informational sessions
- visiting a Graduate Equivalency Diploma (G.E.D) program
- exploring local sites in the city
- learning to navigate the public transportation system
- going to local museums and art shows
- shopping at the mall
- investigating potential career options

Skill development and community integration were two of the cornerstones of the Jump Start program. Young adults with psychiatric disabilities stated they wanted to have the same "normal" experiences of growing up as their peers-completing school, finding a job, making friends-but often lack the skills, supports and opportunities to do so. In addition to receiving the support of a mentor, participants' chose and participated in semester-long classes that lasted 12-14 weeks. The instructors in the class taught skills that facilitated the participants' career development and recovery process. Many participants figured out how to "test the waters" by making their own choices and decisions, but also worried about failure. Participants' who felt or had been told that they may not be very good at anything are often unsure about what to do with their lives. Jump Start not only tried to address the "normative" issues facing young people, but also the unique needs of young people at various stages in the process of coming to terms with having a severe psychiatric disability.

Career Development Classes

There were two levels of career development classes to meet the diverse needs and readiness levels of the participants. The first was career exploration and the second was career planning. The participants chose which class best meets their interests, skills, and abilities at this point in their career journey. Through the career classes, the participants explored many career and educational avenues in hands on, supportive ways. The career exploration class assisted participants who were confused about what to do for work or who were unsure of what steps to take to achieve their goals. This career exploration class covered topics such as identifying your values and preferences, researching career options, evaluating what is the best fit for you, building a resume,

and informational interviewing. In the career planning class, the instructors supported the participants in trying to achieve the right match for their unique talents and strengths. This career planning class covered topics such as building a resume, creating a cover letter, how to sell yourself to the right employer, job getting and keeping strategies, how to understand a company's work culture, how to make yourself a valued employee, how to handle challenging co-workers and bosses, and how to create a long-term career plan.

School, volunteering, internships and work all can be important parts of recovery. Developing skills has the potential to help participants maintain employment and be effective students and/or employees. In both career classes, the participants were educated about how to make informed decisions about their careers, given what is important to them. Participants researched potential jobs, companies, colleges and careers using the Internet, libraries, visiting companies and through informational interviewing. As participants progressed, they were also encouraged and assisted in seeking further schooling, volunteering, internships and/or paid work. These career classes featured structured lessons, presentations and guest speakers in a discussion format that encouraged participants to share and learn from one another's experience as well.

To facilitate the integration of young adults into the community and into the career field of their choice, the program fostered partnerships with the community. The partners included:

- The Museum of Science
- The Medical Foundation
- Year Up

- Children's Hospital, Boston
- Spaulding Rehabilitation Hospital
- Hyatt Regency, Cambridge
- Angell Memorial Animal Hospital
- Massachusetts Rehabilitation Commission
- The New England Aquarium
- Boston Workforce Development Coalition
- Vinfen Human Services
- Super Employment People
- Schwartz Communications Company
- M-Power- a consumer run advocacy group
- Looney & Grossman Law Firm
- Human Services Research Institute

Skills Development Classes

The program offered two levels of computer classes to participants: introductory and advanced. Participants took assessment tests to see which level best matched their abilities and interests. In the computer classes, the instructors taught Microsoft Office Suite in a hands-on manner so the participants can apply it to both professional and educational venues. The introductory level course focused on Microsoft Word, and also demonstrated how to use the Internet, especially in terms of supporting a job or school search process.

The instructors in the advanced computer course taught Microsoft Excel, a spreadsheet operation program, and Microsoft PowerPoint, which allowed participants' to create personalized slide shows on their computers. The advanced computer course also provided an introduction to web design using Dreamweaver. The course introduced concepts and concerns for designing web pages and web sites for personal and professional audiences.

To address the educational needs of Jump Start participants, the program added Graduate Equivalency Diploma (G.E.D.) classes with staff and mentor instructors. The

program design did not have GED classes but the participants asked that these courses be incorporated into the program because they wanted assistance with this goal. Many participants did not have high school diplomas and have not been successful in other GED preparation programs.

A living well seminar assisted the participants in their health and wellness goals. The class increased the participants' readiness to change lifestyle patterns by raising awareness of health issues, providing knowledge and skills to live a healthy life. In this twelve-week class, wellness topics were based on participants' interests. These topics included meditation and mindfulness, journaling, yoga, exploring how food relates to our feelings, medication and symptom management, spirituality, sexuality, and life enhancing strategies for relaxation and stress relief.

We encouraged Jump Start participants to enroll in up to two classes in the Recovery Center each trimester. Promoting recovery through personal choice and self-determination, the Recovery Center fostered physical, emotional, mental, social, and spiritual well-being. The Recovery Center offered individuals the opportunity to participate in an educational infrastructure designed to support and enhance their journey towards recovery. The academic year was divided into 12-week trimesters. The program uses an adult education model, in which participants took classes from four domains: Work, Education, Personal Development, and Wellness. Classes include Personal Fitness, Yoga, Tai Chi, Writing, Drawing, Painting, The Art of Organization, The Recovery Workshop, Journaling As A Tool For Recovery, Accounting, Communication and Friendships, and the Wellness Recovery Action Plan (WRAP) Course.

Both Jump Start and the Recovery Center focused on the person not on the disability. The staff de-emphasized the identity of the participant as a diagnosis, and encourages the personhood of the participant. The program was based upon the belief that participants have the inner strength, knowledge and skills to achieve their goals. Individuals with severe psychiatric disabilities at the Center were not simply managing symptoms but are striving to live well, develop skills, and achieve re-integration into the community through education and personal growth.

Participant Activities

Jump Start participants, staff and mentors collaboratively planned outings and activities that promoted self-esteem, community connections, and opportunities to socialize. These events included bowling, billiards, a benefit walk for the Massachusetts Society for the Prevention of Cruelty to Animals and the Angell Memorial Animal Hospital, A Friends and Family Event to educate and share ideas about recovery and hope, volunteering at the Boston Food Bank, softball games, and attending local sporting events.

One event featured a Jump Start participant and her mother performing a play they wrote called "The Dangers of Empathy." Their work dramatizes the real life experiences of the pain, tragedy, and darkly comic moments of the participant's childhood mental illness. Through song, poetry, movement, drama, and music, the performers tell of their path to understanding and healing. Dr. Leroy Spaniol, a leader in the family support dynamics of individuals experiencing psychiatric disabilities, facilitated a discussion after the play. Many participants, staff and individuals from the community came to the event.

Applying the Supported Education Model in Career Development

The supported education model asserts that a learning situation must involve both the teacher and participant in the challenge of experiencing and understanding the material together. The supported education model lends itself particularly well to the career development process. For example, in career development class, when the SE program staff draw parallels between what employers are looking for in employees and what the participants are looking for when they interview a new therapist for the first time, the class engages in some real dialogue. The participants recognize the usefulness of the skills they already possess but did not know were applicable. Taking the role of guides rather than experts, the program staff and the participants feel that they are creating learning parallels together and bridging the gap between work and life. Instead of giving a dry lecture on the top ten rules of interviewing, the program staff facilitates a learning experience that will help the participants gain a clearer picture of their career and life goals, creating an environment conducive to learning through the establishment of trust and mutual respect. SE program staff encourages the participants to reflect on their lives and take action toward their own development. Any teacher can mechanically impart knowledge that one can give back on an interview or in a test. Only a skilled teacher can involve individuals in the process of creating a new level of understanding together.

Focusing their energies on what job the participant would like to pursue, not on the barriers that have obstructed them in the past, the program staff helps the participants determine what competencies they would like to develop. They also help the participants carefully construct a realistic strategy to obtain their self-articulated

goals. The process of goal setting is critical to the participants' development. This process helps them identify what they want and clarify what resources and systems the program has to support them in their processes. It also helps the participants to break down their goal setting processes into tangible and quantifiable steps toward its completion. This sense of ownership is crucial to the participants' overall success in all elements of the program. Anthony & Blanch (1987) demonstrate that most individuals experiencing severe psychiatric disabilities fail in their attempts to work if they are not properly supported in their endeavors. Therefore, the SE program staff uses a supported education model that emphasizes the development of skills and supports that are embedded in an educational infrastructure. The program directs its efforts toward finding jobs for individuals experiencing severe psychiatric disabilities that they would potentially enjoy doing or attempting to help them find a job that is a stepping stone for future employment goals. Staff assists individuals in moving towards a life that is consistent with their personal goals and values. This strategy increases job retention rates dramatically (Hutchinson et al., in press). The program staff views themselves as individuals who probe for questions and guide the learning experience. Furthermore, they see themselves as coaches who continually help to challenge and support the participants in progressing toward their self-articulated goals. They maintain that the classes in the context of a supportive educational infrastructure assist the participants in the self-discovery, skill development, and job search processes that will lead them toward greater self-sufficiency. The program staff also believes that participants must be committed to and feel ownership for their job search and career development in order to be successful. Additionally, staff creates a supportive atmosphere that puts forth

clear and realistic expectations for participants based on what they state they are committed to achieving. The program believes that in order for participants to achieve their goals, the participants must be an integral part of their own development and that they must take responsibility and control of the decisions they are making and actions they are taking in their lives

An Example of Situated Learning

In attempting to "bridge" the space in learning from what is known to what is unknown, situational parallels can be an important part of the learning process, particularly for young adults who benefit most from concrete examples that directly relate to their everyday experiences. Building upon parallels that young adults can relate to, like comparing the job search to searching for a boyfriend or girlfriend, for example, can demystify the job search process and make it more easily intelligible for young adults. One activity that resonates with individuals with psychiatric disabilities is searching for a place to live. So, using this experience that most of the individuals can relate to, one can use it as a "scaffold" to build upon the known aspects of exploring what is know about the apartment hunt process, then borrowing the idea of "searching" and apply it to looking for a job. First, when teaching individuals problem solving and decision making skills it is useful to breakdown the criteria into manageable pieces or mini-steps. Separating out categories of apartments into groups, for example, one with "ideal" or "perfect" characteristics, one with "good" or "reasonable" characteristics, and one with "poor" or "undesirable" characteristics is a clear and concise way to help the participants visualize the process and make it more concrete. The first column or ideal list may have on it an amazing location, a fireplace, a Jacuzzi, walk in closets, large

bright rooms with lots of windows and natural light. Then in the second column there may be a good place that is close to public transportation, that has oil heating, has a big bathroom, has roomy closets, regular rooms and adequate artificial light. Then in the third column, there may be an apartment that it less than desired or unacceptable with characteristics such as near a noisy factory, no centralized heating system, no shower only a bath tub, has little closet space, small rooms with poor lighting and few windows. This would be an unpleasant place to live. Afterwards a discussion may be had about what characteristics one may swap for another such as, an individual with a lot of clothes being willing to take a longer walk from the public transportation in exchange for larger closet space. Then the parallel is clearly outlined for the individuals that as you search for a job, one will not automatically find the job of one's dreams immediately. One has to evaluate what is truly important and what could be reasonably tolerated if other things were existent at the job. Just like in choosing an apartment, there are things that are critical-location, affordability and cleanliness-that are important to most individuals and a lot of other factors that are more personal and are best evaluated by one's own set of criteria.

An ideal job might be close to one's home, have little phone or paperwork, have a phenomenal salary, be personally satisfying everyday and add tremendous value to many individuals lives. A good job may be accessible by public transportation, may have a reasonable amount of phone and paperwork, might have a salary that is of livable wage, would be personally satisfying to perform on most days and has the potential to add value to people's lives. A poor job might have a very far commute with a lot of traffic both ways, require lots of phone calls and endless paperwork, have a very low

salary, would not be personally rewarding and has very little potential to add value to people's lives. Then, a discussion would take place about how participants would weigh out pros and cons of each criterion.

Questions posed to the participants such as, if you were offered an interesting job with a good salary would you be willing to do an hour and a half commute that involves one bus and one train? Would having a job that was interesting to you be worth the time and commitment of an hour and a half commute? Another question that could be posed to the participants, such as, if the job was a stepping stone to help you get to the next job that you really wanted in the future would you take the job if the pay was not much more than minimum wage? These are important exercises to assist young adults in the critical process of decision-making skills. Life is about making choices and unfortunately young adults with psychiatric disabilities are not well-equipped to make these challenging decisions. For young adults with psychiatric disabilities, it is difficult to make abstract value choices and to understand hypothetical consequences of their actions. Therefore, creating a concrete strategy that was based on ideas and experiences that they could relate to in their own lives is helpful in the decision making process. The more accessible and real the job search process becomes, the more likely the young adult will actively participate in it. Below are the participants' thoughts on their desire to experience situated learning in order to safely develop their competence and confidence.

Explanation of the Change in Structure of the Classes

The relationship between staff and participants in the classes was an important example of person-centered services in practice, but it was especially apparent in the GED classes. It is at times extremely challenging to sit with a participant who is having great difficulty and lashing out at everything and anyone around them, to truly listen for the meaning of what they are saying. For example, several participants so strongly and articulately voiced their disappointment in the program and a desire for a Graduate Equivalency Diploma (GED) class. To address the educational needs of Jump Start participants, the program added GED classes with staff and mentor instructors. The program design did not have GED classes but the participants asked that these courses be incorporated into the program because they wanted assistance with this goal. Many participants did not have high school diplomas and had not been successful in other GED preparation programs. Although there was no room in the budget, a three-day a week class was created to assist participants in their education goal of a GED. Mentors, whose time had not been fully committed by their mentees and who had a teaching background helped tutor participants in the GED. The relationship between staff and participants in the classes was an important example of person-centered services in practice, but it was especially apparent in the GED classes as was explained in Chapter 4.

In the beginning of the program, there were two different choices of career class. The first section was Exploring Your Career Potential and the second was Developing Your Career Potential. The participants' chose which class they wanted to be in. Yet there was still a lot of variation where each participant skill level and career interest was

in this career exploration and development process. Certain participants wanted help deciding what would be a good next job step, some wanted help going back to school, some wanted help obtaining an entry level job just for pocket money. Therefore during one particularly challenging Exploring Your Career Potential class, the participants were expressing their frustration that the class was not meeting their needs enough, which they talk about at length in the interviews. The participants stated that they were dissatisfied with the direction of one of the two career development classes. After listening to the feedback from the class as well as participants in a one on one meeting, it was decided to increase the staff to participant ratio in the class, so that at the latter part of the class participants could receive more personalized attention from a career counselor. This mid-semester challenge definitely put the staff's level of responsiveness and flexibility to the test.

Since the participant's opinion were clearly that they wanted more individualized attention, the staff met together and rearranged the format of the class based on the participants feedback. The class still started out the same way. The instructor would check in to see how each participant was doing and then have a brief instructional discussion or activity, then a short break. After the break, additional staff came in to meet in small groups of two or three participants to work specifically on their goals. One participant's goal was to finish his resume by the end of the class. Another participants' goal was to get an informational interview. Another participant's goal was to have an informational interview with a rap artist. One participant's goal was to get a job, any job.

The participants' groups were arranged according to the participants' goals, which was challenging because the participants' attendance was variable and staff's availability was challenging at times. The feedback from participants regarding this new class format was very positive. Participants stated that they felt they were able to make their goals more open and explicit in these one-on-one meetings and therefore reach their goals more quickly in the smaller groups. Also more time was made available for one-on-one meetings for participants outside of class time to work on their individual career goals as well.

APPENDIX D

REASONABLE ACCOMMODATIONS

Examples of Reasonable Accommodations

Common reasonable workplace accommodations include job coaching on the job, supportive job coaching from off site, assistance in the hiring process, flexible scheduling, changes in training and supervision, or modified job duties (MacDonald et al., 2002). A specific example of someone who needs a reasonable accommodation would be an individual with psychiatric disabilities who might have difficulty handling time pressures and multiple tasks. A supervisor could then break down a large and complicated task into smaller, more manageable ones with specific instructions around prioritizing. The supervisor could also check in regularly with an employee to estimate time needed to complete the project (MacDonald-Wilson, 1997). If an individual with disabilities had difficulty screening out environmental stimuli, such as sounds, sights, or odors, which interfered with focusing on tasks as a result of his or her disability, several accommodations might be appropriate (MacDonald-Wilson, 1997). Examples of such accommodations or workplace solutions could include moving the printer away from the work station, allowing the employee to wear headphones, or installing high partitions around the area (MacDonald-Wilson, 1997).

Research on Reasonable Accommodations

MacDonald-Wilson, Rogers, Massaro, Lyass and Crean (2002) conducted a multi-site study to help identify and accommodate functional limitations in the work place. The study was conducted on 191 individuals with psychiatric disabilities who were participating in one of twenty-six supported employment programs. Most of the individuals in the study were placed in the service industry in low-skill jobs. In order to be part of the study, individuals had to be working for at least three months from 1994

through 1995. Individuals needed to have disclosed their disability. A functional limitation is an incapacity caused by the disability that might interfere with job performance (MacDonald-Wilson, 1997).

To be eligible for the study, individuals also needed to be receiving at least one reasonable workplace accommodation. Findings stated that the more limitations a person had, the more co-worker and supervisor support hours were provided per month. The study also found that cognitive limitations were the strongest and most consistent predictors of the number of accommodations provided. Individuals with cognitive and social limitations were likely to receive accommodations involving human assistance. Individuals with physical limitations, on the other hand, were more likely to receive flexible scheduling accommodations (MacDonald-Wilson et al., 2002).

The outcome data indicated that the most common difficulties leading to accommodations for employees with psychiatric disabilities were challenges around interacting with others, such as interviewing for the job; clarifying instructions; interpreting feedback; and socializing with co-workers (MacDonald-Wilson et al., 2002). Difficulties in learning the job tasks included prioritizing work tasks and remembering the sequence of tasks. Struggles in maintaining work involved working without breaks, standing for long periods of time, and time management. Problems with managing symptoms or coping with stress at work involved relaxing, adjusting to work changes, managing distracting thoughts and feelings, and responding to stressful situations (MacDonald-Wilson et al., 2002).

When assessing an individual with a psychiatric disability for a reasonable accommodation, it is crucial to conduct this process on a case-by-case basis. Each

individual's strengths and abilities must be carefully considered before any recommendation of an accommodation can be made. Furthermore, most employers are not aware that the majority of accommodations are low cost and easy to implement. Data collected by the Job Accommodation Network (JAN) provides evidence that employers who have implemented accommodations for individuals with psychiatric disabilities have profited financially (Duckworth, 2003). These reports show that more than half of all accommodations cost less than five hundred dollars and that most employers receive more than five thousand dollars in profit (Duckworth, 2003). One example of a low-cost reasonable accommodation is a noise muffler that lessens the amount of auditory stimuli for an individual with a psychiatric disability so that they are better able to focus their work without distraction.

BIBLIOGRAPHY

Achenbach, T. M. (1991a). *Integrative guide for the 1991 CBCL/4-YSR, TRF profiles.* Burlington: University of Vermont, Department of Psychiatry.

Adler, A. (1930). *The Education of Children.* London: Bradford and Dickens. (reprinted in 1935, 1947, and 1957).

Adler, A. (1958). *What life should mean to you.* New York: Capricorn.

Adler, A. (1964a). The individual psychology of Alfred Adler. In H.L. Ansbacher & R.R. Ansbacher (Eds.), *The individual psychology of Alfred Adler* (pp. 1-344). New York. Fundamental of individual psychology.

Adler, A. (1964b). *Social interest: A challenge to mankind.* New York: Capricorn.

Ahrens, C., Frey, J., & Burke, S. (1999). An individual job engagement approach for persons with severe mental illness. *Journal of Individual Psychology, 65*(4), 17-24.

Akabas, S. H. (1994). Workplace responsiveness: Key employer characteristics in support of job maintenance for people with mental illness. *Psychosocial Rehabilitation Journal, 17*(3), 91-101.

Alder, A. (1937). The progress of mankind, individual psychology. Reprinted from Adler, A. (1991). An introduction to individual psychology. *Individual Psychology, 47*(1), 1-224.

Alexander, R. (2003). *Understanding the american with disabilities act.* Retrieved January 12, 2003 from http//: www.consumerlawpage.com/article/disact.shtml.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental Disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Anderson, C. M., Reiss, D. J. & Hogarty, G. E. (1986). *Schizophrenia and the family.* New York: Guildford Press.

Anthony, W. A. (1979a). *Principles of psychiatric rehabilitation.* Baltimore: University Park Press.

Anthony, W. A. (1982). Explaining "psychiatric rehabilitation" by an analogy to "physical rehabilitation." *Psychosocial Rehabilitation Journal, 5,* 61-66.

Anthony, W. A., & Blanch, A. (1987). Supported employment for persons who are psychiatrically disabled: A historical and conceptual perspective. *Psychosocial Rehabilitation Journal, 11*, 5-23.

Anthony, W. A., Cohen, M. R., & Farkas, M. D. (1990). *Psychiatric rehabilitation.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Anthony, W. A., Cohen, M., Farkas, M. D, & Gagne, C. (2002). *Psychiatric rehabilitation (*2nd ed.). Boston: Boston University, Center for Psychiatric Rehabilitation.

Anthony, W. A., & Farkas, M. D. (1989). Psychiatric rehabilitation programs: Putting theory into practice. In M. D. Farkas & W. A. Anthony (Eds.), *The future of psychiatric rehabilitation* (pp. 226-239). Baltimore: John Hopkins University Press.

Anthony, W. A., Howell, J., & Danley, K. S. (1984). Rehabilitation of the psychiatrically disabled. In M. Mirabi (Ed.), *The chronically mentally ill: Research and services* (pp. 215-237). Jamaica, NY: Spectrum Publications.

Azrin, N. H., & Besalel, V. A. (1980). *Job club counselor's manual: A behavioral approach to vocational counseling.* Baltimore: University Park Press.

Bandura, A. (Ed.). (1971). *Psychological modeling: Conflict theories.* Chicago: Aldine-Atherton.

Bandura, A. (1977). *Social learning theory.* Englewood Cliffs, NJ: Prentice Hall.

Basaglia, F. (1982). Riabilitazione e controllo sociale. In F. Basaglia & F. Basaglia Ongaro (Eds.), *La maggioranza deviante*. Torino, Italy: Einaudi.

Bassuk, E. L., & Gerson, S. (1978). Deinstitutionalization and mental health services. *Scientific American, 238*(2), 46-53.

Beard, J. H., Propst, R. N., & Malamud, T. J. (1982). The fountain house model of psychiatric rehabilitation. *Psychosocial Rehabilitation Journal, 5*(1), 47-53.

Bisset, K. S. (2000). *Promoting positive outcomes: A holistic approach to the development of competencies of low-income single mothers.* Paper presented at University of Massachusetts, Amherst.

Blackorby, J., & Wagner, J. (1996). Longitudinal postschool outcomes of youth with disabilities: Findings from the National Longitudinal Transitional Study. *The Council for Exceptional Children, 62*(5), 399-413.

Bland, R. C., & Orn, H. (1980). Schizophrenia: Schneider's first-rank symptoms and outcome. *British Journal of Psychiatry, 137,* 63-68.

Bleuler, M. (1978). Die schizophrenen Geistessrungen im Lichete Kranken- und Familiengeschiten. George Thieme Vetiag, Stutgart (1972) (Translated by S. M. Clemens, The Schizophrenic Disorders, Long-term patient and Family Studies). New Haven: Yale University Press.

Blotcky, M. J., Diimperio, T. L., & Gossett, J. T. (1984). Follow-up of children treated in psychiatric hospitals: A review of studies. *American Journal of Psychiatry, 141,* 1499-1507.

Bond, G. R. (1992). Vocational rehabilitation. In R.L. Liberman (Ed.), *Handbook of Psychiatric Rehabilitation* (pp. 244-275). New York: Macmillan.

Bond, G. R., Drake, R. E., Becker, D. R., & Mueser, K. T. (1999). Effectiveness of psychiatric rehabilitation approaches for employment of people with severe mental illness. *Journal of Disability Policy Studies, 10*(1), 18-52.

Bond, G. R., Resnick, S. G., Drake, R. E. , Xie, H., McHugo, G. L., & Debout, R. R. (2001). Does competitive employment improve nonvocational outcomes for people with severe mental illness? *Journal of Consulting and Clinical Psychology, 69*(3), 489-501.

Borkin, J. R., Steffen, J. J., Ensfield, L. B. Krzton, K., Wishnick, H. & Wilder, K. E., (1998). *Development and evaluation of the Recovery Attitudes Questionnaire.* Manuscript submitted for publication.

Brady, M. (2003). The Americans with Disabilities Act as it affects person with thought disorders: Your right as employee or job candidate. Retrieved on January 12, 2003. Reprinted from the Village Voice. www.bgsm.edu/voice/ada.html

Brown, C. (1996). A comparison of living situation and loneliness for people with mental illness. *Psychiatric Rehabilitation Journal, 20*(2), 59-63.

Carkhuff, R. R. (1969). Facilitation and retardation in helping processes. *Helping and Human Relations, 2.* New York: Holt, Rinehart, & Winston.

Carkhuff, R. R. (1971). Training as a preferred mode of treatment. *Journal of Counseling Psychology, 18*(2), 123-131.

Carkhuff, R. R. (1972). An approach to counselor education. In D. E. Hendrickson & F. H. Krause (Eds.), *Counseling and psychotherapy training and supervision* (pp. 245-345). Columbus, OH: Chase E. Merril.

Carkhuff, R. R. (1987). *The art of helping.* Amherst, MA: Human Resources Development Press.

Chamberlain, J. (1984). Speaking for ourselves: An overview of the ex-psychiatric inmates' movement. *Psychosocial Rehabilitation Journal, 8*(2), 56-63.

Chamberlain, J. (1989). Psychiatric rehabilitation programs: Ex-patient groups and psychiatric rehabilitation. In M. D. Farkas & W. A. Anthony (Eds.), *Psychiatric rehabilitation* (pp. 207-216). Baltimore: Johns Hopkins University Press.

Chamberlain, J. (1990). The ex-patient's movement: Where we've been and where we're going. *Journal of Mind and Behavior, 11*(3-4) 323-336.

Chiftick, R. A., Brooks, G. W., Irons, F. S. & Deane, W. N. (1961). *The Vermont story.* Burlington, VT: Queen City Printers.

Ciompi, L. & Moller, C. (1976). *Lebensweg and alter schizophrenia, einekatamnestic lonzeitstudies bis ins senum.* Berlin: Springer-Verlag.

Clark, H., & Davis, M. (2002). *Transition to adulthood: A resource for assisting young people with emotional or behavioral difficulties.* Baltimore: Paul H. Brookes Publishing Co.

Cohen, P., & Hesselbart, C. S. (1993). Demographic factors in the use of children's mental health services. *American Journal of Public Health, 83,* 49-52.

Cohen, S., & Hoberman, H. (1983). Positive events and social supports as buffers of life change stress. *Journal of Applied Social Psychology, 13,* 99-125.

Cohen, S., Mermeslstein, R., Kamark, T., & Hoberman, X. (1985). Measuring the functional components of social support. In I. G. Sarason & B. R. Sarason, (Eds.), *Social support: Theory, research, and application* (pp. 332-473). The Hague, Holland: Martinus Nijhoff.

Cook, J. A., & Hoffschmidt, S.J. (1993). Comprehensive models of psychosocial rehabilitation. In R. W. Flexer & P. A. Solomon (Eds.), *Psychiatric rehabilitation in practice* (pp. 81-97). Boston: Andover Medical Publishers.

Corey, G. (1991). *Theory and Practice of Counseling and Psychotherapy* (4th ed.). Pacific Grove, CA: Brooks/Cole Publishing Company.

Costello, A., Edelbrook, C., Dulcan, M. K., Kalas, R., & Klaric (1984). *Development and testing of the NIMH Diagnostic Interview Schedule for Children (DISC-C) on a clinical population: Final report (Contract No. RFP-OB-81-002T).* Rockville, MD: National Institute of Disability.

Costello, E. J. (1989). Development in child psychiatric epidemiology. *Journal of the American Academy of Child and Adolescent Psychiatry, 28,* 836-841.

Danley, K. S. & Anthony, W. A. (1987). The choose-get-keep model: Serving severely psychiatrically disabled people. *American Rehabilitation, 13*(4), 6-9.

Danley, K. S., & MacDonald-Wilson, K. (1996). *Operational guidelines: The choose-get-keep approach to employment support.* Boston: Boston University Center for Psychiatric Rehabilitation.

Davis, M., & Clark, H. B., (2000). *Transition to adulthood. A resource for assisting young people with emotional and behavorial difficulties.* Baltimore: Paul H. Brooks Publishing.

Davis, M., & Vander Stoep, A. (1997). The transition to adulthood among children and adolescents who have serious emotional disturbance: Part 1. Developmental transitions. *Journal of Mental Health Administration, 24*(4), 400-427.

Davis, M., Yelton, H., & Katz-Levy, R. (1995). *State and child adolescent mental health: Administration and policy laws.* Tampa: University of South Florida, Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Deane, W. N., & Brooks, G. W. (1976). *Five-year follow up of chronic hospitalized patients.* Waterbury, VT: Report from Vermont State Hospital.

Dedrick, R. F., Greenbaum, P. E., Friedman, R. M., Wetherington & Knoff, H. M. (in Press). Testing the structure of the Child Behavorial Checklist/4-18. Using confirmatory factor analysis. *Educational and Psychological Measurement.*

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11-19.

Deegan, P. E. (1992). The independent living movement and people with psychiatric disabilities: Taking back control over our own lives. *Psychosocial Rehabilitation Journal, 15*(3), 3-19.

Deegan, P. E. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal, 19,* (3), 91-97.

Deegan, P. E. (1997). Recovery and empowerment for people with severe psychiatric disabilities. *Social work in Health Care, 25(3),* 11-24.

Delman, J., & Jones, A. (2002). *Voice of youth in transition. The experience of aging out of the adolescent public mental health system in Massachusetts: Policy implications and recommendations.* In a report submitted to the Massachusetts Department of Mental Health, sponsored by Consumer Quality Initiatives, Inc., Dorchester, MA.

Dembo, T., Leviton, G. L., & Wright, B. A. (1956). Adjustment to misfortune-A problem of social psychological rehabilitation. *Artificial Limbs, 3*(2), 4-62.

Demographic Status Report. (2003). Boston: Boston University, Center for Psychiatric Rehabilitation.

DeSisto, M.J., Harding, C. M., Ashikaga, T., McCormick, R.V. & Brooks, G. W. (1995a). The Maine-Vermont Project, a matched cohort comparison of long-term outcome. 1. Matched comparison of cross-sectional outcome. *British Journal of Psychiatry, 167,* 331-338.

DeSisto, M. J., Harding, C. M., Ashikaga, T., McCormick, R. V., & Brooks, G. W. (1995b). The Maine-Vermont three decade studies of serious mental illness, II. Longitudinal course comparisons. *British Journal of Psychiatry, 167,* 338-342.

Dincin, J. (1981). A community agency model. In J. A. Talbott (Ed.), *The chronically mentally ill* (pp. 212-226). New York: Human Sciences Press.

Drake, R. E., & Becker, D. R. (1996). The individual placement and support model of supported employment. *Psychiatric Services, 47,* 473-475.

Drake, R. E., McHugo, G. J., Bebout, R. R. Becker, D.R., Harris, M., Bond, G.R., & Quimby, E. (1999). A randomized clinical trial of supported employment for inner city patients with severe mental illness. *Archives of General Psychiatry, 56,* 627-633.

Drake, R. E, Osher, F. C. Noordsy, D. L., Hurlbut, S. C., Teague, G. B., & Beadett, M. . (1990). Diagnosis of alcohol and use disorders in schizophrenia. *Schizophrenia Bulletin, 16,* 57-67.

Ducksworth, K. (2003). Accommodation ideas for individuals with psychiatric disabilities. Retrieved January 12, 2003. http//:www.janweb.wvu.edu/media/psychiatric.html

Ellison, M. L., & Russinova, Z. (2002). *A national survey of professionals and managers with psychiatric conditions: A portrait of achievements and challenges.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Erikson, E. H. (1963). *Childhood and society* (2nd ed.) New York: Norton.

Erikson, E. H. (1968). *Identity: Youth and crisis.* New York: Norton.

Erikson, E. H. (1982). *The life cycle completed.* New York: Norton.

Fabian, E. (1992). Supported employment and the quality of life: Does a job make the difference? *Rehabilitation Counseling Bulletin, 36,* 84-97.

Farkas, M. D., & Anthony, W. A. (1989). *Psychiatric rehabilitation programs: Putting theory into practice.* Baltimore: John Hopkins University Press.

Farkas, M. D., O'Brien, W. F., & Nemec, P. B. (1988). A graduate level curriculum in psychiatric rehabilitation: Filling a need. *Psychosocial Rehabilitation Journal, 12*(2), 53-71.

Frankl, V. (1963). *A man's search for meaning.* Boston: Beacon Press.

Frankl, V. (1967). *Psychotherapy and existentialism.* New York: Simon and Schuster.

Frankl, V. (1969). *The will to meaning: Foundations and applications of logotherapy.* New York: New American Library.

Freidman, R. M., Katz-Levy, J. W., Manderscheid, R.W., & Sondheimer, D.L. (1996). Prevalence of serious emotional disturbances in children and adolescents. In R. W. Manderscheid & M. A. Sonnenschein (Eds.), *Mental health in the United States,* (pp. 71-89). Rockville, MD: U.S.Department of Health and Human Services.

Freud, S. (1936). *Inhibitions, symptoms and anxiety.* London: Hogarth Press.

Freud, S. (1938). *The basic writings of Sigmund Freud.* New York: The Modern Library.

Freud, S. (1953). Civilization and its discontents. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol 21, pp. 64-145).

Gardos, G., Cole, J. O., & LaBrie, R. A. (1982). A 12-year follow-up study of chronic schizophrenics. *Hospital. Community Psychiatry, 33* (12), 983-984.

Gindis, B. (1998). Scaffolding children's learning: Vygotsky and early childhood education. Retrieved on January 26, 2003 from http//:www.bgcenter.com/scaffold.html. Published in *School Psychology Interntational, 19*(2), 189-191.

Glauser, B., & Strauss, A. (1967). The discovery of grounded theory. Chicago:Adline.

Glauser, B., & Strauss, A. (1968). Time for dying. Chicago:Adline.

Greenbaum, P. E., & Dedrick, R. F. (1996). National adolescent and child treatment study. Outcomes for children with severe psychiatric disabilities. *Journal of Emotional and Behavioral Disorders, 3*(4), 130-146.

Grob, S. (1983). The chronic psychiatric patient in the community. In I. Barofsky & R. D. Budson (Eds.), *Principles of treatment. Psychosocial rehabilitation centers: Old wine in a new bottle* (pp. 265-280). Jamaica, NY: Spectrum Publications.

Hall, B. (1975). Participatory research: An approach for change. *Convergence*, 24-32.

Halter, C. A., Bond, G. R., & DeGraaf-Kaser, R. (1992). How treatment of persons with serious severe psychiatric disabilities is portrayed in undergraduate psychology textbooks. *Community Mental Health Journal, 28*(1), 29-42.

Harding, C. M. (1994). An examination of the complexities in the measurement of recovery in severe psychiatric disorders. In R. J. Ancill, D. Holliday, & G. W. MacEwan (Eds.), *Schizophrenia: Exploring the spectrum of psychosis* (pp. 153-169). Chichester: J. Wiley & Sons.

Harding, C. M., Brooks, G. W., Ashikaga, T., Strauss, J. S., & Breier, A. (1987b). The Vermont longitudinal study of persons with severe mental illness: II. Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. *American Journal of Psychiatry, 144*(6), 727-735.

Harding, C. M., Zubin, J., & Strauss, J. S. (1987). Chronicity in schizophrenia: Fact, partial fact, or artifact? *Hospital and Community Psychiatry, 38*(5), 477-486.

Harrison, V. (1984). A biologist's view of pain, suffering and marginal life. In F. Dougherty (Ed.), *The depraved, the disabled and the fullness of life.* Delaware: Michael Glazier.

Hatfield, A. B. (1987). Families as caregivers: A historical perspective. In A. B. Hatfield & H. P. Lefley (Eds.), *Families of the mentally ill: Coping and adaptation* (pp. 3-29). New York: The Gilford Press.

Hatfield, A. B. (1990). *Family education in mental illness.* New York. Guilford Press.

Hawk, A B., Carpenter, W. T., & Strauss, J. S. (1975). Diagnostic criteria and 5-year outcome of schizophrenia; a report from the International Pilot Study of Schizophrenia. *Archives of General Psychiatry, 32,* 343-347.

Hogarty, G. E., Anderson, C. M., Konrblith, S. J., Greenwald, D. P., Javana, C. D., & Moadonaia, M. J. (1986). Personal indicators in the course of schizophrenia research group. Family psychoeducation, social skills training, and maintenance psychotherapy in the aftercare treatment of schizophrenia: I. One year effects of a controlled study on relapse and expressed emotion. *Archives of General Psychiatry, 43,* 633-642.

Hogarty, G. E., Anderson, C. M., Konrblith, S. J., Greenwald, D. P., Ulrich, R. F., & Carster, M. (1991). Family psychoeducation, social skills training, and maintenance Psychotherapy in the aftercare treatment of schizophrenia II. Two year effects of a controlled study on relapse and adjustment. *Archives of General Psychiatry, 48,* 340-347.

Huber, G., Gross, G., & Schottler, R. (1979). Schizophrenic: Verlaufs and sozialpsychiatrische Lanqzeitundersuchungen an den 1945 bis 1959, in *Bonn Hospitalisierten schizophrenen Kranken. Monographien aus dem Gesamtgebiete des Psychiatric, Bd. 21.* Berlin: Springer-Verlag.

Hughes, R. A., Woods, J., Brown, M. A., & Spaniol, L. (1994). *An introduction to sychosocial rehabilitation.* Columbia, MD: International Association of Psychosocial Rehabilitation Services.

Hutchinson, D. Anthony, W., Massaro, J., Rogers, E. S., & Cash, D. (in press). *An integrated supported education and employment computer training program for persons with psychiatric disabilities.* Boston: Center for Psychiatric Rehabilitation, Boston University.

International Association of Psychosocial Rehabilitation Services. (1994). *An introduction to psychiatric rehabilitation.* Columbia, MD: Author.

International Association of Psychosocial Rehabilitation Services. (1996). *Core principles of psychiatric rehabilitation.* Columbia, MD. Author.

International Association of Psychosocial Rehabilitation Services. (2000). *Principles of psychiatric rehabilitation.* Columbia, MD: Author.

Ivey, A. E. (1977). Cultural expertise: If the counselor is to become a teacher, toward what should the teaching be directed? *Canadian Counselor, 12,* 23-29.

Jarrow, J. (1992). *Subpart E : The impact of Section 504 on postsecondary education.* Columbus, OH: Association on Higher Education and Disability.

Johnson, S. L., Meyer, B. Winnet, C., & Small, J. (1999). Social support and self-esteem predict changes in bipolar depression but not mania. *Journal of Affective Disorders, 58*(2) 79-86.

Kastner, L. & Wyatt, J. (1997). *The seven year stretch: How families work together to grow through adolescence.* Boston: Houghton Mifflin.

Keating, D. (1990). Adolescent thinking. In S. S. Feldman & G. R. Elliot (Eds.), *At the threshold: The developing adolescent* (pp.54-89). Cambridge, MA: Harvard University Press.

Kirsch, B. (1996). Influences on the process of work integration: The consumer perspective. *Canadian Journal of Community Mental Health, 15,* 21-37.

Kirsch, B. (2000). Work, workers and workplaces: A qualitative analysis of narratives of mental health consumers. *Journal of Rehabilitation,* 66(*4),* 24-30.

Kramer, P., & Gagne, C. (1997). Barriers to recovery for people with severe psychiatric disabilities. In (Eds.), *Psychological and social aspects of psychiatric disabilities* (pp. 467-476). Boston: Center for Psychiatric Rehabilitation, Boston University.

Lather, P. (1991). *Getting smart. Feminist research and pedagogy within the postmodern.* New York: Routledge and Kegan Paul.

Lave, J., & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation.* New York: Cambridge University Press.

Lazarus, A. A. (1996b). The utility and futility of combining treatment in psychotherapy. *Clinical Psychology: Science and Practice, 3(1),* 59-68.

Leaf, P. J, Alegra, M., Cohen P., et al. (1996). Mental health service use in the community and schools: Results from the four community MECA study. *Journal of American Academic Child Adolescent Psychiatry, 35,* 889-97.

Lehman, A. F. (1983). The well-being of chronic mental patients. *Archives of General Psychiatry, 40,* 369-373.

Lehman, A. F., & Steinwachs, D.M. (1998). At issue: Translating research into practice: The Schizophrenia patient outcomes research team (PORT) treatment recommendations. *Schizophrenia Bulletin, 24*(1), 1-10.

Leighton, A. H., & Leighton, D. P. (1949). Gregorio, the handtrembler. A psychobiological personality study of a Navaho Indian. In Leighton & D. P. Leighton, (Eds.), *Peabody Museum papers.* Cambridge, MA: Harvard University Press.

Leitner, L., & Drawgow, J. (1972). Battling recidivism. *Journal of Rehabilitation, 8,* 9-31. Crisis counseling management saved my life, 40 (4) 1974. 19-20.

Levine, I., & Spaniol, L. (1985). The role of families of the severely mentally ill in the development of community support services. *Psychosocial Rehabilitation Services, 8*(4), 83-94.

Lukoff, K., Liberman R., & Nuechterlein, K. (1986). Symptom monitoring in the rehabilitation of schizophrenic patients. *Schizophrenia Bulletin, 12,* 578-602.

MacDonald-Wilson, K. (1997). *Frequently asked questions about employees with psychiatric disabilities-tips and resources on the ADA, job accommodations and supervision.* Boston: Boston University, Center for Psychiatric Rehabilitation.

MacDonald-Wilson, K., Rogers, E. S. & Anthony, W. A. (2001). Employment of individuals with psychiatric disabilities. *Journal of Occupational Rehabilitation, 11*(3), 455-485.

MacDonald-Wilson, K. L., Rogers, E. S, Massaro, J. M, Lyass, A., & Crean, T. (2002). An investigation of reasonable workplace accommodations for people with psychiatric disabilities: Quantitative findings from a multi-site study. *Community Mental Health Journal, 38*(1), 35-50.

Maguire, P. (1987). *Doing participatory research: A feminist approach.* Amherst, MA: Center for International Education, University of Massachusetts, Amherst.

Mannion, E. (1996). Resilience and burden in spouses of people with mental illness. *Psychiatric Rehabilitation Journal, 20*(2), 13-23.

May, R. (1950). *The meaning of anxiety.* New York: Ronald Press.

May, R. (1961). *Existential psychology.* New York: Random House.

May, R. (1967). *The art of counseling.* Nashville, TN: Abingdon Press.

May, R. (1981). *Freedom and destiny.* New York: Norton.

McFarlane, W. A., Dushay, R. A., Deakins, S. M., Stastny, P., Lukens, E. P., Toran, J., & Link, B. (2000). Employment outcomes in family-aided assertive community treatment. *American Journal of Orthopsychiatry, 70*(2).

Meyer, A. (1919). The life chart, *In contribution to medical and biological research.* Hoeber, NY: Paul B.

Moon, S., Goodall, P., Barcus, M., & Brooke, V. (1986). *The supported work model of competitive employment for citizens with severe handicaps: A guide for job trainers.* Richmond, VA: Rehabilitation Research and Training Center, Virginia Commonwealth University.

National Capacity Building Institute sponsored by the National Center on Secondary Education and Transition (NCSET), December 9th and 10th, 2002. *Coordination and management of supports and services for individuals with disabilities from secondary to postsecondary education and employment.* Boston, MA Author

National Mentoring Center. (2002). *Measuring the quality of mentor-youth relationships* (Technical Assistance Packet #8). Portland, OR: Northwest Regional Educational Laboratory.

National Public Radio Latino population trends. Retrieved on March 15, 2004 from http://www.npr.orgnews/national/1997/aug/970811.lationos.html p. 1

Nemec, P. B., McNamara, S., & Walsh, D. (1992). Direct skills teaching. *Psychosocial Rehabilitation Journal, 16*(1).

Nietzsche, F. (1966). *The basic writings of Nietzsche.* New York: The Modern Library.

Perls, F. S. (1969). *Gestalt therapy verbatim.* Moab, UT: Real People Press.

Pratt, C. W., Gill, K. J., Barrett, N. M., & Roberts, M. M. (1999). *Psychiatric rehabilitation.* San Diego, CA: Academic Press.

Prochaska, J. (1979). *Systems of psychotherapy: A transtheoretical analysis.* Homewood, IL: The Dorsey Press.

Rank, O. (1941). *Beyond psychology.* New York: Dover Publications, Inc.

Rank, O. (1968). *Will therapy and truth and reality.* New York: Alfred A. Knopf, Inc.

Rapport, M. (2000). *Hiring individuals with mental illness: Coaxing the mental health system toward a recovery-based model.* National Alliance of the Mentally Ill. Retrieved January 26, 2003 from htttp//:www.nami.org/pressroom/001002.html.

Raskin, N. J. (1948). *The development of nondirective therapy.* Retrieved January 12, 2003 from http//:www.signs.portents.com/~matt/cct.development.html 1-23.

Raskin, N. J. (1978). Becoming - a therapist, a person, a partner, a parent, a... *Psychotherapy: Theory, Research, and Practice, 15*(4), 345-387.

Revell, W., Jr., Wehman, P., & Arnold, S. (1984). Supported work model of competitive employment for persons with mental retardation: Implications for rehabilitation services. *Journal of Rehabilitation, 50,* 33-38.

Rice, P. D. & Miller, L. S. (1998). Health economics and cost implications of anxiety and other mental disorders in the United States. *British Journal of Psychiatry, 173*(34) 4-9.

Riffar, T. F., Maki, D. R., & Wolf, A W. (1986). *Applied rehabilitation counseling.* New York: Springer Publishing Company.

Rogers, C. R. (1942). *Counseling and psychotherapy.* Cambridge, MA: The Riverside Press.

Rogers, C. R. (1946). Significant aspects of client-centered therapy. *American Psychologist, 1,* 415-422.

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications, and Theory.* Boston: Houghton Mifflin.

Rogers, C. R. (1956). Client-centered therapy: A current view. In F. Fromm-Reichmann & J. L. Moreno (Eds.), *Progress in psychotherapy* (pp. 223-264). New York: Grune & Stratton.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21,* 95-103.

Rogers, C. R. (1959). Non-directive counseling: Student-centered therapy. Synopsis of student centered therapy, from Carl Rogers, A theory of therapy, personality, and interpersonal relationships, as developed in the student-centered framework. In S. Koch (Ed.), *Psychology: A study of science, 3* (pp. 212-221). New York: McGraw Hill.

Rogers, C. R. (1961). *On becoming a person.* Boston: Houghton Mifflin.

Rosenberg, M. (1965). *Society and the adolescent self-image.* Princeton, NJ: Princeton University Press.

Rusk, H. A., & Taylor, E. J. (1949). *New hope for the handicapped: The rehabilitation of the disabled from bed to job.* New York: Harper.

Rutman, T. D. (1987). The psychosocial rehabilitation movement in the United States. In A. T. Meyerson & T. Fine (Eds.), *Psychiatric disability: Clinical, legal, and administrative dimensions* (pp. 197-220). Washington, DC: American Psychiatric Press.

Saraceno, B., & Tognoni, G. (1989). Methodological lessons from the Italian experience. *International Journal of Social Psychiatry, 35*(1), 98-109.

Scheid, T. & Anderson, C. (1995). Living with chronic severe psychiatric disabilities: Understanding the role of work. *Community Mental Health Journal, 31,* 63-176.

Schoepenhauer, A. (1964). *Studies in pessimism.* London: Swan Sonnenschein & Co.

Schultz, A. (1967). *The phenomenology of the social world* (G. Walsh & F. Lenhert, Trans.). Chicago: Northwestern University Press.

Seidman, I. (1998). *Interviewing as qualitative research.* New York: Teachers College Press.

Schontz, F. C. (1965). Reactions to crisis. *Volta Review, 67,* 364-370.

Schontz, F. C., (1975). The psychologist aspects of physical illness and disability. New York: Macmillan.

Schontz, F. C. (1978). Psychological adjustment to physical disability: Trends and in theories. *Archives of Physical Medical Rehabilitation, 59,* 251-254.

Skinner, B. F. (1941) *Beyond freedom and dignity.* New York: Knopf.

Smith, M. "Otto Rank, Psychologist and Philosopher" Retrieved January 12, 2003 from http//: www.ottorank.com.

Spaniol, L., Gagne, C., & Koehler, M. (1999). Recovery from serious severe psychiatric disabilities: What is it and how to support people in their recovery. In R. P. Marinelli & A. E. Dell Orto (Eds.), *The psychological and social impact of disability* (4th ed.) (pp. 32-87). New York: Springer Publishing.

Sparrow, S. S., Balla, D. A., & Cichetti, D. V. (1984). Vineland adaptive behavior Scales: Interview edition. *Survey promotional manual.* Pines, MN: American Guidance Service.

Spieger, M. D. & Guevremont, D. C. (1998). *Contemporary behavior therapy* (3rd ed.). Pacific Grove, CA: Brooks/Cole.

Stanton, A. H., Guderson, J. G., Knapp, P. H., Frank, A. F., Vannicelli, M. L., Schnitzer, R., & Rosenthal, R. (1984). Effects of psychotherapy in schizophrenia: Design and implementation of a controlled study. *Schizophrenia Bulletin, 10*(4), 89-111.

Stoddard, S., Jans, L., Ripple, J., & Kraus, L. (1998). *Chartbook on work and disability in the United States, 1998: An inhouse report.* Washington, DC: U. S. National Institute on Disability and Rehabilitation Research.

Strauss, A. & Corbin, J. (1990). *Basics of Qualitative Research. Grounded theory procedures and Techniques.* London: Sage Publications.

Strauss, J. S., & Carpenter, W. T. (1974). Prediction of outcome in schizophrenia II. Relationship between predictor and outcome variables. *Archives of General Psychiatry 31,* 37-42.

Strauss, J. S., Kokes, R. F., Ritzler, B., Harder, D.W.,& VanOrd, A. (1978). Patterns of disorder in first admission psychiatric patients. *Journal of Neourological Mental Disabilities, 11,* 611-625.

Strong, S. (1998). Meaningful work in supportive environments: Experiences with the recovery process. *American Journal of Occupational Therapy, 52,* 31-38.

Torrey, K. (1995). *Surviving schizophrenia.* New York: Harper Perennial.

Truax, C. B., & Carcuff, R. R. (1967). *Toward effective counseling and psychotherapy.* Chicago: Aldine.

Tsuang, M. T., Woolson, R. F., and Fleming, J. A. (1979). Long-term outcome of major psychoses, schizophrenia and affective disorders compared with psychiatrically symptom-free surgical conditions. *Archives of General Psychiatry, 36,* 1295-1301.

United Department of Health and Human Services. (1999). *Mental Health: A report of the Surgeon General –executive summary.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Vander Stoep, A. (1992). Through the cracks: Transition to adulthood for severely psychiatrically impaired youth. In A. Algarin & Friedman (Eds.), *The 4th annual research conference proceeding, a system of care for children's mental health: Expanding the research base.* Tampa, FL: 357-368. University of South Florida, Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Vander Stoep, A. (1994). *Transition to adulthood: issues of youth with mental illness.* Presented at the American Public Health Association Annual Meeting, New York, NY.

Vander Stoep, A., Beresford, S., Weiss, N. S., McKnight, B., Cauce, A. N., & Cohen, P. (2002). Community-based study of the transition to adulthood for adolescents with psychiatric disorder. *American Journal of Epidmeilogy 152*(4), 352-362.

Vander Stoep, A., Taylor, B., Blanchard, T., Tomlin, S., & Anderson, L. (1995). *Mental health case management for homeless youth in King County, WA.* Paper presented at American Public Health Association meeting, Washington, DC.

Van der Veen, H. (1988). Rehabilitation in Dutch mental health care. *International Journal of Mental Health, 17(3),* 24-32.

Vygotsky, L. (1998). Scaffolding children's learning : Vygotsky and early childhood education. *School Psychology International, 19*(2), 189-191.

Vygotsky, L. S., & Luria, A. R. (1993). *Studies on the history of behavior.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Walls, R. T., Dowler, D. L. & Fullmer, S. L. (1990). Incentives and disincentives to supported employment. In F .R. Rusch (Ed.), *Supported employment: Models, methods and issues* (pp. 251-269). Sycamore, IL. Sycamore Publishing.

Warner, R., & Polak, P. (1995). The economic advancement of the mentally ill in the community: 2. Economic choices and disincentives. *Community Mental Health Journal, 31,* 477-492.

Wolpe J. (1958). *Psychotherapy by reciprocal inhibition.* Stanford, CA: Stanford University Press.

Wolpe, J., & Lazarus, A. (1966). *Behavior therapy techniques.* Oxford: Pergamon Press.

World-Health Organizations. (1979). *Schizophrenia: An international follow-up study.* Wiley, Chichester. Author.

Wright, B. A. (1960). *Physical disability-psychological approach.* New York: Harper.

Wright, B. A. (1983). *Physical disability: A psychosocial approach* (2nd ed.). New York: Harper & Row.

Wybrow, P. (1997). *A mood apart: The thinkers guide to emotion and its disorders.* New York: Harper Collins Publisher, Basic Books.

Zinman, S. (1982). A patient-run residence. *Psychosocial Rehabilitation Journal, 6*(1), 3-11.